# MENTAL HYGIENE

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## FREEDOM, RESPONSIBILITY, AND SELF-CONTROL *


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FRANKWOOD E. WILLIAMS in his well-known paper, *Confronting the World,*[1] contended that the two most important evidences of the maturation of personality in late adolescence are, first, the development of independence, and second, the attainment of normal heterosexuality. The first involves emancipation from the home and such matters as choice of occupation. The second concerns the arrival at adult interest in the opposite sex—untrammeled consciously or unconsciously, so far as that is possible, by infantile and childish fixations upon one or both parents—and release from parentally determined fears of the mating tendencies in the young man or woman. Williams' paper may be considered one of the classics of mental hygiene.

It seems to me, however, that to-day we need to emphasize in addition two other factors that indicate maturity in the individual—that is, responsibility for acts and conscious self-control. *Responsibility* means the ability and the willingness to take the consequences of one's acts. It implies ethically that the person is a free moral agent, one who is capable of being deterred or controlled by considerations of social sanctions, legal and moral. In these days of the decline

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[1] *Confronting the World: The Adjustments of Later Adolescence,* by Frankwood E. Williams, M.D., in *Concerning Parents; A Symposium on Present-day Parenthood.* New York: New Republic, Inc., 1926. pp. 137–59.

of traditional parental and home control over young people, in the midst of talk about "emancipation," "liberty," and "self-determination of one's life," in this period of emphasis upon freedom from restraint, and of fear on the part of parents (influenced by so-called progressive educators), there is, it seems to me, grave danger that young people may fail to realize that in human life, as in material nature, cause and effect continue to operate—that in society as in nature there is a determinism which we cannot gainsay or ignore.

Freedom on the negative side means the absence of, or the exemption from, restraint by the power or control of another. In the more positive sense, freedom means free choice of ends and means in action. In our society this implies self-determination of marriage, vocation, religion, and politics. It is closely bound up with our doctrine of rights. But it is not to be confused, as we shall see, with license or absence of responsibility. Freedom from parents is, therefore, not merely a matter of getting away from home ties through uncontrolled indulgence of emotions and appetites. The young person who sets out upon this course sooner or later discovers that in the end his "freedom" enmeshes him in difficulties and problems of which he did not dream. Nor can the matter be considered merely one of age or locality.

Parents are partially responsible for this situation. Throughout childhood and early adolescence they keep their children in emotional bondage to them, exemplified by the children's dependence on the parents for spending money, for educational opportunities and advice, for the provision of opportunities for recreation, and for general protection of health and safety. Then, to take a common instance, the children are shipped off to college, and the parents are shocked when they fail in their scholastic work, when they spend more than their allowance, when they drink too much, when in the end they come back asking or expecting to be picked up, to be rescued from their difficulties. Parents do not sufficiently prepare their children for independence and freedom by building up in advance habits and attitudes of responsibility.

This situation has arisen partly because of our shift to urban life and to what the sociologist calls secondary-group organization of society—that is, a society marked by the dis-

appearance of home and garden, the predominance of specialization of occupation, individualization of choice as to friends, religious life, and forms of recreation, and a general "touch-and-go," impersonal kind of social contact. Life in our cities, as compared to country and village life of a few generations ago, is superficial.

Formerly a boy or girl living in a village or a small town was trained in responsibility for the care of stock and for kitchen and other household duties. The widespread disappearance of what were known forty years ago as "chores" for young people illustrates what I mean. In village and small-town life of 1900, in most families the boy had a cow to care for, chickens to feed, or a garden to weed. And the girls of a family, as they grew up, learned to cook, mend, sew, and care for the household. In contrast, to-day with over half of our population living in cities, large percentages of our young people grow up without such obligations, without even a chance to assume responsibilities for such tasks. It is true that by club work, by expanding the function of the school, by controlled recreational programs, and by the introduction of young people's organizations into church work, we have tried to do something to offset this situation, to provide substitutes for these former opportunities of the preadolescent and adolescent to manage affairs of his own. Yet, to face the situation honestly, we must admit that we have failed for the most part to find adequate substitutes for these earlier habits and attitudes. Even in rural districts to-day, with the introduction of specialized labor-saving machinery, there has been a gradual decline in these functions for young people.

As a result our boys and girls are growing up without the fundamental training necessary for the freedom and consequent responsibility which all sane people believe to be essential to maturity. True, we provide money, clothes, education, and travel for our children. But are these what they require most for their own growth? How often have I heard the lament of a mother saddened by some untoward episode in the life of her son: "How could he do such a thing after all my husband and I have done for him?" Or how often have I had a young woman report that her parent had upbraided her with some such remark as "After all I've done for you,

how could you do this?" Or worse still: "Look what you've done to *me*!" Or in other situations, how frequently do parents rush in to pick up their young people, to get them out of difficulties because they fear "the worst" from their "misconduct" (as they define it).

The crux of the problem itself seems to lie just here: Both children and parents operate on the expectancy that once the children get into trouble (financial, sexual, vocational, educational) the parent will revert to his former rôle and rescue the child—brush away his tears, as it were, and set him again upon the highway to rosy success. Of course when parents are not faced with an immediate crisis of this sort, they will assure you that they would not think of doing this, that George and Mary are now on their own. But once confronted with a real difficulty, the older habits and attitudes reappear, and the parent performs in his time-worn rôle of guardian and guide and rescuer from harm! And the young man or woman—they prate of their freedom, want to throw off parental control; but once they find themselves "in a tight place," they run to their parents. By keeping our children dependent upon us financially until they have completed their college and professional preparation, we assume that they are responsible to us and that we are responsible for them. In our society financial control usually implies all the other forms. Thus we throw about the older adolescent and the young adult all sorts of protective devices. We send him to college, but are not prepared to see him really emancipated and fully responsible. Young people in college have for years, perhaps, longed for freedom. Now they have their freedom, without any corresponding responsibility. They want to "have their cake and eat it, too." Later, when they fail or break down or come back to us, we turn and blame them for ingratitude, when with equal justice we might well blame ourselves.

But instead of blaming them, or ourselves, let us examine more closely the personality as it matures. Perhaps we can find what in our society makes for responsibility and what inhibits or prevents its development. Let us note again some of the fundamental features of the psychology of the personality. *Personality* may, for our purposes, be defined as a combination of the habits, attitudes, and ideas (including

opinions, beliefs, and values) of an individual, as these are organized in reference to his rôles and status in society. Personality is absolutely dependent upon social interaction with others and upon the culture in which the individual grows up and in which he lives.

The "self" that is the core of the personality is always developed in reference to other persons. It is a social product. As George Herbert Mead, Charles Horton Cooley, and John Dewey, to note three important figures in social psychology, long ago emphasized, the self arises out of—in fact, is dependent for its development upon—the manner in which other persons react to an individual. And as William James well said, "a man has as many social selves as there are individuals who recognize him and carry an image of him in their mind." The self develops when we learn to react as others expect us to react and when we come to accept this form of reaction in ourselves as normal and proper because others so consider it. To state the matter in another way, the self is a composite of the various rôles that we play on the stage of life; and the various scenes and acts of this drama correspond to the various groups of persons with whom we interact or participate in common activities. To carry the dramatic analogy further, some persons change their rôles almost completely from scene to scene—that is, from group to group—while others reveal a more or less consistent and common pattern in their behavior or their rôle-taking in every scene—that is, in every group. The latter represents what we call "the integrated personality," the man of strong moral character, the person whose actions we can predict as morally sound because we know, within certain reasonable limits, how he will react in any and every situation that confronts him. The extreme opposite of such a man is one who is never the same in two groups or situations. Such a man we should quite properly call "insane," and we should probably lock him up in a mental hospital.

From the rôles that we play in the societal drama, we acquire a certain prestige or standing. This we call status. Moreover, our standing with our fellows changes with the scene or group with which we are reacting. Thus a man who is a proud father to his family may be a humble workman in a factory; or a prominent banker may have no significant

status with his wife and daughters at home because he refuses to conform to the amenities of "polite and proper society."

Now the cultural standards—that is, the customs, laws, and traditions—of various groups in which one plays a part will determine largely both the rôle and the status of any given individual. Put in other words, these groups will predetermine, by their customary, expected patterns of response or reaction, the functions and standing, the individual freedom, responsibility, maturity, and conscious direction of the individual, so long as he remains operating within the group. And it is obvious with little observation that there is a wide variation in the demands of the various groups to which one belongs. In business and professional circles, for example, their exists one set of standards, demands, or expectancies; another in the relations of parents to children; and in sex and marital life, in one's club and fraternal or religious life, still others. For example, in business and professional circles there is an insistence on stability, consistency, and responsibility in behavior which reflects the objectivity of modern economic culture. So, too, in strictly professional education, in scientific research, in training in the fine arts, the intellectual abilities are constantly forced into a more or less logical and consistent framework. But as one passes from economic activity to political, to recreational and leisure time, to religious activities, and to the more intimate relations of family and marital life, while there may be outward conformity to standards, there is often less and less demand for consistency, stability, and self-control.

In other words, *responsibility is related to the group demands.* In economic life there is an insistence on taking the consequences of one's actions. In politics there is less of such insistence, but still a good deal, and it is the ideal of all political reformers that there should be more. In recreation and leisure (except where these themselves touch the economic patterns) there is much more individual choice and much more chance to escape the consequences of our conduct. In the family there are traditional responsibilties such as that the husband shall support his family, that the wife shall care for the children, that the children shall obey their parents. Nevertheless, a great deal of irresponsibility is developed in family relations because we persist, as I have pointed out, in

maintaining verbally high standards of consistency and accountability, but fail in the crises to follow through with a strict cause-and-effect logic. This is especially likely to be true in the modern family, which has lost so much of its former stabilizing influence of economic activity, educational and religious functions, and provision for familial recreation. In other words, in the very interrelations of spouses to each other and of parents to children in the modern world, we have not yet developed those standards of expectancy which cut down or eliminate infantilisms, futile daydreaming, and continued attempts to escape responsibility.

Thus there are various degrees or areas of maturity and responsibility. The individual develops these qualities only in response to social demands and the influence of other people upon him. We remain impulsive, emotional, unstable, given to fear, anger, or uncontrolled affection, unless we have been trained otherwise. In short, maturation is for most persons a matter of levels or segments of the total personality. In some relations the individual may be hard-headed, able to direct his own affairs efficiently, while in others he may have continued at infantile and childhood levels of reaction, depending upon wheedling, upon tears, upon threats of violence, upon any number of *power devices* which are common to children, but which by the general consensus of mature and well-balanced adults are considered undesirable.

As a matter of fact, we have actually come to accept as normal a great deal of this infantile and childish behavior. This is exemplified in the continued use by women of sexual appeal in order to win success in business, in the continued use of violence on the part of fathers in disciplining their children, in the emotional appeals of politics and religion. It is nowhere better illustrated than in the unchecked power which persons of wealth or of culturally inherited class status exercise over those around them. It is not uncommon to discover that a man who has followed all the expected patterns of our economic culture of consistency, responsibility, and objectivity in acquiring wealth uses his wealth and its prestige in exploiting his help, his family, his children, and his friends.

Because of the loosening of primary-group controls, the

rapidity of changes in culture generally, and the ideology that interests, wishes, emotions, and feelings are predominant over rational thought or logic, there is a common assumption that the individual can do little (should not even try to do anything) to manage or plan the course of his life. While no one questions the power of irrational and emotionally colored wishes and interests to motivate conduct, it is hard to believe that we can or should do nothing about deliberately directing our lives. The whole history of man's culture and the rise of individuality and morality negate this narrow interpretation of modern psychology. Self-control means the pre-direction and coördination of one's impulses and acts, particularly as this direction and coördination center around some goal, ideal, or plan. It is characterized by foresight and control determined by mature—that is, socialized—consideration of the self in reference to others. It is thus closely linked up with both freedom and responsibility. It implies, therefore, that we can plan our lives in advance.

But this plan, frankly, must be coördinated with the deeper, unconscious impulses and motives. The inadequacy of the older view lies in its assumption that the unconscious impulses and motives were animal, base, unworthy, and dangerous. It was up to us as individuals to repress them completely, and much of Christian and Judaistic morality was concerned with devices to negate and deny these biological urges which are fundamental to man's living. And when later we discovered the truer meaning of these urges, there arose in the land a philosophy which said in effect, "This is the way nature made us. One cannot do anything about these impulses; therefore, follow them, since there is nothing else to do"; or "Nature 'intended' us to follow our impulses." This attitude is an admission that we have not yet learned how to manage and sublimate these so-called "baser" impulses.

Let us note in more concrete detail some factors to be taken into consideration in effecting a reunion, if you please, of logic and intelligence with the deeper biological urges and emotions.

1. We need to recognize that, though interests and wishes determine the aims or ends of living, these may be moralized and socialized in terms of the demands of our fellows.

Recognition of the fact that the self arises from building up rôles and the status that others require of us should convince us that a full life is possible only when we recognize the anticipations or claims of others upon us. This is exactly what *socialization* and *moralization* mean.

2. The sacrifice of the biological (lower) urges and emotional outlets can be satisfactorily accomplished only by finding in their place socially accepted emotional outlets. It is important to remember that the more lasting, more permanent satisfactions arise not when we live in a world of emotional and impulsive ups and downs like a spoiled child or spoiled adult, but when the emotions are less intense perhaps and more continuous, but correlated with intellectual interests and activities of a creative and artistic sort. (And by creative and artistic activities I do not mean merely the fine arts, but the art of living with others.)[1]

3. In our love life itself, maturity is marked by mutual responsiveness, appreciation of and recognition of the sacredness of personality—that is, of the *self* of others. The mature individual will have cut himself loose from the mother's apron strings or broken his childish father fixation. He will show no traces of infantile temper tantrums in the face of denials or crisis. He will show no projection of blame upon others when he cannot have his own way at every turn.

4. Strong hedonistic wishes or pleasure-seeking selfishness will be sublimated into self-expression in creative art which may bring prestige, although perhaps only from intimate friends and family. Or it may find its outlet in a deep and abiding love of righteousness in allegiance to some high cause which aims at improving the conditions of living for all.

5. The revamping of the major social situations in which we operate will assist in bringing about maturity. So long as large masses of men, women, and children remain in a condition of economic insecurity, they will be the victims of their emotions and urges for security, which will be played upon by every demagogue or would-be dictator who alleges that he will be their savior if they will follow him and do his bidding. So long as we do not provide a culturally acceptable and sound outlet for phantasy thinking in children, so long as we

[1] See *The Dance of Life*, by Havelock Ellis (Boston: Houghton Mifflin Company, 1923) for a discussion of some phases of this matter.

play fast and loose with the child's emotions and fundamental habit training, so long as we ourselves as adults control children and adolescents as if they had only emotions and no intelligence, so long shall we continue to foster difficulties of personal maturity which confront us on every hand.

It is obvious that this matter has implications wider than that of developing in our adolescents a feeling of responsibility to accompany their freedom so far as vocational choice and normal sexual adjustment go. It has a bearing on the whole problem of the kind of public life we shall have. Social and emotional immaturity, a sense of freedom without a corresponding sense of responsibility for acts, a philosophy that one cannot plan or direct his own life by "taking thought"—all these lay the foundation for the destruction of political and economic individualism and the democracy which our forefathers gained for us at such great sacrifice. In a world of continuing and even increasing insecurity and consequent confusion of aims, these foundations in the personality make every one of us the prey of every wind of doctrine, of every power-seeking agitator who with bright and glittering promises would lead us into the utopia of safety and comfort. We shall suffer from a mistaken ideal if we give childish devotion to some *Führer*, to some magic economics, or to the ideology of some totalitarian state. These will keep us in emotional bondage and deny us the opportunity to grow up and to become both free and responsible. All the great minds of history have demonstrated that such growth in freedom and responsibility is the only way in which greatness in a society or in an individual can be attained.

# PSYCHOANALYTIC ASPECT OF MENTAL HYGIENE AND THE ENVIRONMENT*

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I WAS glad to accept the invitation of the Illinois Society for Mental Hygiene because a personal tie connects me with the mental-hygiene movement. It was through this movement that I had my first contact with this country, when six years ago I accepted the invitation of my friend, the late Dr. Frankwood E. Williams, to attend the First International Congress on Mental Hygiene in Washington. In those days Frankwood Williams was an enthusiastic believer in mental hygiene. It was impossible that some of this enthusiasm should not be imparted to those who were in close contact with him.

The International Congress, itself to a large degree Frankwood Williams' own creation, was an impressive event. About three thousand people of all nationalities, interested in the social and medical aspects of mental health, gathered in Washington and tried to express themselves with greater or less success in the English language. In Washington I began to understand the story of the Tower of Babel in its full significance. Not so much the differences in tongue evoked this impression, but the wide variety of attitudes and ideas as to what is mental health, what are the important factors responsible for maladjustment. In this scientific Babel every point of view found its advocate. One heard conservative organic theories: mental disease is inherited and based on some organic process in the brain; it has the same causation as physical illness, such as infection or some degenerative process in the brain tissues. At the same time in another room a sociologist tried to persuade his audience that man can be transformed and changed into anything through his

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environment. Organic psychiatrists and sociologists represented the two opposite poles, the radical left and right wings which threatened to crush the small, but supposedly dynamic group of psychoanalysts who, like the liberals, took the medium position between these two extremes. We were both courted and attacked from both sides.

For me this International Congress was a very revealing experience. When walking in the corridors of the Washington hotels, one would hear in one corner a group of organicists tearing to pieces some speaker who had pleaded for the all-importance of the social situation. One could easily imagine how these excellent men of science, raised in histological laboratories, must have felt: "What a degeneration of classical medical thought! Disease is no longer understood in terms of the exact sciences, but in the vague generalities of the sociologist." The next moment one found one's self in the midst of a sociologically oriented group who looked down on the organicists as representatives of the Middle Ages. Toward the psychoanalysts they assumed a somewhat patronizing, mildly critical attitude. "Of course we know," they said, "that you pay attention to the postnatal factors, but you do not know yet that every individual is born into a very definite cultural milieu which rigidly determines the kind of personality he will become."

Soon after this conference, Frankwood Williams' interest turned more and more toward the sociological factors in personality development. He visited Russia several times and became more and more convinced that mental hygiene in our western civilization is futile. It was two years ago that here, in this very place, he expressed the most pessimistic attitude regarding the possibilities of mental hygiene. His position was that so long as there is social and especially economic injustice, mental hygiene is of no use. Psychiatry is too weak a weapon to combat the fears and uncertainties inherent in our social structure. According to his view, a just social order will provide an automatic solution of the problems of mental health.

It is obvious that our friend Williams became the victim of an extreme pessimism and an extreme optimism at the same time. Man cannot escape mental unbalance in an imperfect

social organization; this is the pessimistic side of his concept. Adjustment to social environment will be no problem in a society that gives full security to its members; this is the optimistic side of his theory, which believes in the possibility of bringing about, with existing human material, a perfect social organization.

I do not feel that a dinner speech or any speech at all is the occasion for trying to solve the difficult problem of the rôle of the environment in personality formation and mental disorder. Psychoanalysis is concerned with just this problem, with the influence of emotional experiences upon the formation of character and mental ailment, yet Freud never discarded the constitutional factor. Who could disregard it who has had wide clinical experience and is confronted with the great fundamental differences that exist among human beings? Freud's life work, psychoanalysis, is, however, a method by which, not the rôle of constitution, but the influence of life experiences can be studied. It even tries, by the help of the psychoanalytic therapy, to erase the pathological effect of childhood experiences. The main contribution of psychoanalysis to this problem consists not only in pointing out the importance of environmental influences in general, but in supplying a method by which these influences can be studied in a specific and precise fashion.

It is obvious that, in approaching the problem of mental health with our present equipment, we cannot do much with hereditary constitution. To control the postnatal development seems the only practicable approach. Mental hygiene, therefore, depends upon a precise knowledge of environmental influences upon normal and pathological development.

Much confusion arises in this field from the lack of precise definition of what is meant by the expression "environmental influences." For the sociologist, this expression means mainly certain traditionally transmitted cultural patterns that determine the individual's behavior in almost every manifestation of his life. They determine not only his social attitude in a broader sense, but also his eating habits, his excremental habits, the way he raises his children, and the way he treats his wife economically and even sexually.

For the psychoanalyst, environmental influences mean

something even more specific. He deals with individuals who belong to the same cultural milieu. The cultural milieu is for him a constant factor, not a variable one as for the anthropologist. Most of the people, I should say all of the people, whom he treats belong to the same type of civilization. It may be that in Europe his patients are Frenchmen, Englishmen, or Germans, and in America they may come from different national groups; nevertheless they all belong to the same western civilization. Yet the human material with which the psychoanalyst deals is extremely variable. He sees a diversity of mental disturbances: hysterias, compulsion neuroses, neurotic criminals, paranoid criminals, and so forth. With the help of his psychological microscope, he sees an extreme variety of mental maladjustments and personalities. He observes frequently quite different types of individual coming not only from the same social group, but even from the same family. He cannot be satisfied with speaking of such general influences as are represented by cultural patterns. He must look for more specific factors which vary from family to family, and which have a different significance even within one family for the different children. For example, the environment of an only child is entirely different from that of another child who is a member of a larger family, although both may belong to the same social group. The environment of the oldest child is different from that of the youngest and that of the middle child. Of course we are speaking here of a subjective or psychological environment. For the anthropologist, whose interest is focused on the culture as a whole system, these differences are not so interesting. He studies the civilization of some part of Africa and compares it with one in Central Australia. For the psychoanalyst, the object of study is the individual, with his specific emotional problems.

This minute study of individual life histories shows us that the most important factors in personality formation are the early experiences of childhood. The nature of these emotional experiences is determined not only by more general factors such as cultural patterns, but also by extremely individual factors, characteristic of each specific family in which the child is brought up. What we learn is that it is just these individual features that are of primary importance—for

example, the question whether the father is temperamental and violent or weak and repressed, or whether the mother is overindulgent, overprotective, or neglectful, sexually frigid toward her husband and consequently overaffectionate toward her children. These are the factors that are of primary influence upon the personality development of the child, and we find them at work not only among Frenchmen, Germans, and Americans, but also among the people of other civilizations. An eminent anthropologist, Linton, in his new book,[1] emphasizes the interesting fact that he found the same types of personality that we know in our western civilization in very divergent cultural milieus.

Unfortunately most of our psychoanalytic experience, as I mentioned above, is obtained from the study of individuals belonging to the western civilization. We cannot, therefore, very well compare the specific influences of different cultural milieus. Certainly I was unable to find radical differences in personality trends or neuroses between Americans and Europeans, but both continents, in spite of important differences, still belong roughly to the same type of civilization. In this connection it is of interest that the analysis of a Chinese patient conducted by Dr. Saul in the Chicago Psychoanalytic Institute has revealed fundamentally the same types of conflict that we find so frequently among Americans and Europeans.

Thus the first impression which the psychoanalyst obtained was that of the universal similarity of the emotional structure of man. This impression was only strengthened by the evidence of folklore and mythology, which shows that in ancient civilizations as well as in those that are contemporaneous, human phantasy, with monotonous repetition, expresses the same fundamental hopes, fears, and conflicts.

I have, however, no doubt that if we were able to compare the psychological structure of a larger number of individuals belonging to different cultural milieus, we should discover certain types of neurotic conflict more frequently in one culture than in another. But I have just as little doubt that probably in all cultures we should find the whole range of

[1] *The Study of Man*, by Ralph Linton. New York: D. Appleton-Century Company, 1936.

almost all possible conflict situations, certain types of conflict predominating in some and others in other cultures. The specific influence of certain cultures one will be able to define only after the technique of analysis has been applied to a large number of individuals belonging to different civilizations.

What seems most impressive in this field, however, is not the difference between, but the universality of, the fundamental motives in cultures widely separated geographically and temporally.

The explanation of these universal features of emotional life lies in the fact that there are a few fundamental emotional and instinctual problems that every child has to solve during his development in any form of social organization. Some of these problems are biologically predetermined and others arise as the result of collective life itself, no matter what the specific form of this collective life. These problems are centered around three fundamental dynamic or biological tendencies. The first is a regressive force in the individual which manifests itself as a resistance against biological maturation; the second is the sexual instinct; and the third, the destructive hostilities in human nature.

The important question for us is to learn the relation of social factors to these biological forces.

The importance of the sexual restrictions which are required in any form of social life was first recognized by Freud. Every civilization requires certain restrictions of the sexual life. In every society the permissible objects of the sexual drive are limited and must be found outside of the family. The nature of the social restrictions are of course necessarily of paramount importance in increasing or diminishing the difficulties involved in sexual maturation. The tendency of the child's sexual drive to attach itself to those persons upon which the child has been dependent—that is to say, the incestuous objects—is the basis of the difficulties provoked by the social restrictions. This leads to the well-known constellation of jealousies and hostilities, which, if unrestricted, would disrupt the unit of society, the family.

Discovered later, and less well known, are those problems which center around the first and third mentioned dynamic

tendencies—around the regressive tendencies in the individual, also called repetition compulsion, and the destructive impulses.

Every child has to adjust itself to the change in its biological situation after birth. Every child depends at first for its nutrition to a high degree upon the mother, no matter whether it is breast fed or bottle fed. This type of nutrition gradually changes to a more independent form, in which the child's organism has to participate more actively. This change is dependent upon a biological change, on dentition. There is no civilization in which children are born with teeth. The psychoanalyst knows the tremendous importance for the child's emotional attitude of the development of teeth. A new era of emotional development seems to start from this period.

A similar revolutionary change takes place when the child learns to walk and to speak, two new important steps on the road toward independence. These faculties develop at a certain period after birth, although certain quantitative differences which may be culturally determined are of great importance.

Sexual maturation is another turning point in the individual's development and is also responsible for a new and fundamental change in the emotional outlook. It ends the status of being a child; the individual becomes able to have children. Emotionally this means a fundamental change. The well-known difficulties of puberty are the best testimony of this. The uncertainty of the adolescent is due to the fact that the mature sexual drive is incompatible with emotional dependence upon the parents. The adolescent personality must live up to his new biological status.

Senescence is the last universal biological change which requires new adjustment on the individual's part.

The important fact which primarily concerns us here is that every individual develops gradually from a biologically and socially dependent creature into a more or less independent human being who has to take care of his own existence and even becomes responsible for the care of others. Psychoanalytic experience shows now that a regressive tendency which works in the opposite direction to this process of

maturation is present in every human being. Every phase of the biological development may serve as a point of fixation. After the child has learned one method of satisfying his biological needs, he has the tendency to stick to this. Every new phase which the inexorable course of biological development requires means a new problem of adjustment—that is to say, of learning. Whenever an individual encounters difficulties in his existence, he is apt to be thrown back upon earlier forms of existence. Every neurosis or psychosis is essentially such a regressive process.

The difficulties of accepting these consecutive steps of biological development may be increased or diminished through external, socially conditioned influences, but they cannot be entirely eliminated. It is obvious, for example, that the customs of child nursing, the amount of independence required of a child at various ages, differ in different civilizations and must have an important influence on the child's development. On the other hand, the individual differences in the mother's attitude within the same civilization are so large that we can always find a mother whose attitude is atypical in her own civilization, but would correspond to the average attitude in another. She might, for example, be overindulgent according to our ideas, but would be considered normal in some other culture, in which mothers wean their children from the breast much later.

After the individual has acquired his biological maturity, he soon becomes also socially independent; that is to say, he must take care not only of himself, but also of his family. At this phase a new difficulty arises which is almost entirely of a sociological nature—the difficulty of economic existence, the economic insecurity that is so characteristic of our own civilization.

Here we arrive at the problem that so deeply impressed Frankwood Williams. He felt that the difficulties inherent in our competitive civilization, which gives so little basis for security, are one of the main factors responsible for the extreme frequency of neuroses and all forms of mental maladjustment in our present time. We must agree with him that the importance of the economic problem should not be underestimated. We know well the paramount influence of

fear in the causation of neurosis. Fear is what induces individuals to a flight from reality to phantasy, which can carry them back into happier periods of their lives when they felt secure and satisfied. This regression can take place only in phantasy, because in reality it is not given to any individual to reassume the happy situations of his childhood. Economic insecurity unquestionably is one important precipitating factor in neurosis. On the other hand, analytical experience teaches us that the resistance of an individual in the struggle for existence is dependent upon the experiences of his early childhood. The ability to endure difficulties varies, according to successes and failures during the processes of biological maturation. Traumatic feeding difficulties, for example, during the early periods of life, in which the problems of nutrition are the center of the child's emotional life, may create a defeatist attitude, a fear of life which the individual will retain throughout his life and which will make him less courageous and resistant in the struggle for existence.

The third group of difficulties centers around the problem of hostility and destructiveness. Every form of collective life is dependent upon a certain amount of inner control by the individual over his destructive tendencies. No society could exist without the development within individuals of restrictive forces which inhibit the free expression of their hostilities against one another. This restrictive force is what we call conscience, which is the result of a complicated psychological development. One universal factor in mental disturbances belongs to the psychology of conscience; it comes from the difficulties of controlling the destructive tendencies. If these cannot find direct expression, there are two important mechanisms by which the individual can give vent to them in spite of his conscience. One is self-destruction, which finds expression in neuroses, psychoses, or even in suicide. The other method is a mechanism which we call projection. In order to evade the restricting influence on one's own conscience, there is a tendency to attribute one's own aggressions to others, and this allows expression of hostile feelings under the pretense of self-defense. A general mistrust and fear of others will be the result. Under the pressure of this fear and mistrust the slightest movement of others, even though rela-

tively harmless, will be interpreted as a vicious attack and will lead to hostile aggressions which are committed in the conviction that one is acting in self-defense.

There is no doubt that in our present competitive civilization there is sufficient real basis for hostilities among the members of the group. But paranoid fear and mistrust increase these objectively justified antagonisms to an extreme degree. Because this tendency to project one's own hostilities on others is so universal, it is no exaggeration to speak of a paranoid feature in our present civilization. This atmosphere of uncertainty, fear, and mistrust is a powerful influence toward driving an individual into neurotic regressions by means of which he tries to escape into phantasy from the unbearable chronic tensions of his real existence.

In short, the hardships of existence increase the individual's regressive tendencies. These, together with the socially required restrictions of his sexual and aggressive impulses, may be considered as the fundamental causes of mental disturbances. The economic and social structure may intensify both the regressive tendency and the difficulties connected with the sexual and aggressive impulses. The specific nature of the social restrictions of the instinctual life, which vary from culture to culture, are of paramount significance. The economic factor has a specific importance for the intensification of the regressive biological tendency, by increasing the difficulties of adult existence.

We must remember, however, that neuroses and psychoses occur among those whose social security is beyond question as well as among those who belong to the underprivileged strata of the population. We do not know what would be the influence upon human beings of a social order which would give easy and absolute satisfaction of all human needs. Our experience with certain individuals whose situation somewhat approximates this mythological wishful phantasy is not too encouraging. A certain amount of thwarting, not too excessive, a certain amount of fear and deprivation are powerful motives in forcing the individual to progress to new adjustments. Neuroses that develop from lack of tension are just as common as neuroses that develop from thwarting. Moreover, it seems that the human animal has so long a phylo-

genetic history of struggle behind him that his whole organism and mentality are shaped for struggle. Of course, struggle does not necessarily mean struggle against one another and does not necessarily consist in a fight for the satisfaction of the most elementary biological needs. The conquest of nature is also a result of human struggles.

Admitting that a social organization under which individuals would have a greater feeling of security and less fear of one another would necessarily contribute toward general mental health, yet it seems to me that it is an extremely utopian attitude to look to a sudden social change which will lead humanity from an imperfect to a perfect social organization, and to lie still until after this miracle shall have happened. One should not forget that the quality of the social organization necessarily depends upon the quality of the human material that participates in the organization. The social qualities of man, especially his ability to control his hostilities, are the only foundations upon which a more stable social order can be based. Some sociologists answer that the hostilities of individuals against one another can be diminished only in a social system in which every one enjoys full security. This alone could eliminate the cause of mutual hostilities. The psychologist's answer is that the improvement of the social order is dependent upon the willingness of individuals to compromise with one another—*i.e.*, upon the development of their social attitudes.

Apparently we find ourselves in a vicious circle: Only a better integrated social order can diminish the mutual hostilities of the members and at the same time this more satisfactory social order is dependent upon a greater mutual solidarity of the individuals. Yet this vicious circle is spurious. It has one vulnerable point. The deep origin of fears and hostilities is in the early childhood development. I see the function of mental hygiene in the disruption of this vicious circle just at this vulnerable point, through scientific control of childhood development. This function is to spread existing psychopathological knowledge and especially to encourage research into the nature of those factors which, in the early phases of life, create fears and hostilities, the main obstacles to progress toward a more harmonious social order.

# AN ANALYSIS OF ONE HUNDRED CONSECUTIVE CASES IN THE MARRIAGE COUNSEL OF PHILADELPHIA

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IN 1932 a group of Philadelphians, representing educational and welfare organizations, religious groups, and the professions interested in studying the preventive approach to family difficulties, met to discuss the work of local agencies in the field of family relations. It was apparent that, in general, help on family problems was being offered only after family difficulty of one kind or another had become crucial. There was little evidence of any effort (except on the part of a few individuals) to approach these problems at an earlier stage, when broad educational procedures or individual counseling might prevent disaster.

In view of these findings, the group decided to establish a new service, called the Marriage Counsel, to which the members of the group stood as advisory sponsors. This service offers to help young married couples, or those contemplating marriage, to a better understanding of common requisites for married life, to help them avoid some of the causes of marital difficulties. Confidential interviews offer young people an opportunity for frank discussion, for obtaining reliable information, and for relieving anxiety about the unknown.

It was decided that this service should begin with no formulated policy, and should proceed slowly and carefully, to find out whether there was need for such work and, if so, in what way this need might best be met.

The work of the Marriage Counsel of Philadelphia has two main divisions—individual consultation and education for marriage and family life.[1] In dealing with clients who desire

[1] See "Has the Marriage Counsel a Place in Community Activity? A Report of Two Years' Work," by Emily B. H. Mudd. *Marriage Hygiene*, Vol. 1, pp. 414–18, May, 1935.

personal help, the Marriage Counsel is considered as a consultative and referring service.[1] It offers consultation in terms of the individual's needs. The service is handled in one or more individual and confidential interviews of approximately one hour each. Privacy and freedom from interruption are provided for in a cheerful, somewhat informal office setting. A carefully selected lending library of technical books and fiction is available during the interviews. If possible, certain books are on the desk. If treatment of emotional or specific problems is indicated over a long period of time, the service includes contact with, and introduction to, organizations and individual specialists acquainted with and cooperating with the work of the Counsel. Some of these specialists can be seen in the Marriage Counsel office by appointment or in the specialist's own headquarters—whichever seems best in the individual case. If occasion for further counseling arises, the client is free to reopen contact with the Counsel. It is felt that a contribution by the client toward the support of the Counsel is, where possible, a psychological advantage. It enables the client to accept help in a dignified way and to leave more freely. The average fee of 100 consecutive clients in 1934–1935 was approximately $1.00.

The second, or educational, division of the work of the Marriage Counsel consists in furnishing speakers to interested groups, organizations, and classes in normal schools and colleges to talk on the work of the Counsel or on more specific subjects relating to preparation for and adjustments in marriage; in organizing seminars with professional group, such as physicians, ministers, educators, and social workers, for the study of particular problems and methods of approach; in coöperating with group leaders and taking part in conferences in allied fields; and in getting out reports and articles. The lending library of carefully selected books already referred to is available in the office for the use of professionals, study groups, and clients. Although details of this phase of the work will not be discussed in this study, it is obvious that it brings a number of clients for private consultation.

[1] See "Some Aspects of Counseling in a Marriage and Family Consultation Service," by Emily B. H. Mudd. *The Family*, Vol. 16, pp. 301–5, February, 1936.

The 100 consecutive cases with which this paper is concerned were seen in 1934–35. These clients were men and women, married and unmarried, referred to the Counsel by physicians, educators, ministers, and social workers (connected with organizations and institutions of the highest standing) or led to it through newspaper articles, lectures, and group work, and, increasingly, through former clients. A classification of the group according to source of reference gave the following results:

| | *Number of cases* | |
|---|---|---|
| Private individuals | 11 | |
| Former clients | 17 | |
| | | 28 |
| *Professional sources:* | | |
| Physicians | 11 | |
| Educators | 13 | |
| Ministers | 4 | |
| | | 28 |
| *Institutional sources:* | | |
| Social agencies | 18 | |
| Educational institutions | 11 | |
| | | 29 |
| *Educational work by Counsel:* | | |
| Courses and talks | 7 | |
| Newspapers articles | 8 | |
| | | 15 |
| | | 100 |

Of the 100 cases, 79 were women and 21 men. Classified by age, they showed the following distribution:

| | |
|---|---|
| 18–20 years | 6 |
| 20–30 years | 61 |
| 30–40 years | 24 |
| 40–50 years | 9 |
| | 100 |

In the matter of religion, they were divided as follows:

| | |
|---|---|
| Catholics | 10 |
| Jews | 8 |
| Protestants | 82 |
| | 100 |

A classification according to occupation placed 56 in skilled occupations, 44 in unskilled.

In regard to marriage status, the data were as follows:

| | |
|---|---|
| Unmarried and not engaged | 17 |
| Engaged | 35 |
| Married up to 5 years | 15 |
| Married over 5 and up to 10 years | 15 |
| Married over 10 years | 10 |
| Married for period unknown | 6 |
| Separated or divorced | 2 |
| | 100 |

To summarize, it may be said that the clients in this series represented a fair cross section of the present social order, both economically and educationally. In age they ranged from eighteen to forty, the majority being between twenty and thirty. The women were almost four times as numerous as the men. There were many more Protestants (which group here includes Quakers) than any other religious group. The married and unmarried were represented about equally, by far the greater number of married having been married under ten years. A cross section of occupations shows that the majority came from the middle groups of low-salaried professions and trades, such as teaching, social work, salesmen, stenographers, clerks, and so forth.

Thirty-seven of the clients contributed to the Counsel anywhere from 75 cents to $10, 63 did not contribute, making an average of $2.10 for those who contributed, and an average of 88 cents for the total 100 clients.

The questions that come up before the Counsel have to do with many phases of human relationship and adjustment, the majority being concerned with the physiology and psychology of sex (young people desiring reliable and adequate information about the functioning and care of their bodies and some understanding of their own feelings and attitudes as well as those of the opposite sex). Specific problems presented by clients include questions of homosexuality, fertility, sterility, contraception, venereal disease, abortion and various types of sex adjustment, parent-child relationships, divorce, and

personality adjustments. Inherent in many of these is the ever-present consideration of the economic situation and all that it entails from the standpoint of marital adjustment. In some of these situations our coöperating specialists in the fields of internal medicine, gynecology and obstetrics, pediatrics, neurology, psychiatry, psychology, child guidance, social work, religion, education, economics, and law are called upon to give additional help. The situations presented by the 100 clients under consideration may be classified into three groups, as follows:

| | *Total* | *Unmarried clients* | *Married clients* |
|---|---|---|---|
| *Pre-marital situations* | 33 | 33 (engaged) | .. |
| *Specific situations:* | | | |
| Unwanted pregnancy | 12 | 6 | 6 |
| Sexual difficulties (frigidity, contraception, venereal disease) | 11 | .. | 11 |
| Childbirth and sterilization | 7 | .. | 7 |
| Advisability of marriage to a particular person (where there is a difference in background, age, religion, etc.) | 5 | 5 | .. |
| Consideration of divorce | 4 | .. | 4 |
| Child guidance | 4 | .. | 4 |
| Preparation of student papers | 4 | 4 | .. |
| Attitudes on sexual matters | 4 | 1 | 3 |
| Sterility (inability to bring about desired pregnancy) | 2 | .. | 2 |
| Assistance in training for counseling, running clinics, etc. | 2 | .. | 2 |
| Adoption of child | 1 | .. | 1 |
| Homosexuality | 1 | 1 | .. |
| Prenatal care and delivery | 1 | .. | 1 |
| Total specific situations | 58 | 17 | 41 |
| *General upset:* | | | |
| Fears, feelings of guilt over sexual matters, personality difficulties with husbands, wives, or families | 15 | 3 | 12 |
| *Total situations recorded* | 108* | 55 | 53 |

* Eight cases appeared in more than one category.

The following correlation between the type of situation presented by these 100 cases and the frequency of their visits to the Counsel is of interest:

| | 1 visit; no other use | 1 visit plus other use | 2 visits plus other use | 3 visits plus other use | 4 visits plus other use | 6 visits plus other use | Number of clients |
|---|---|---|---|---|---|---|---|
| Pre-marital situation | 1 | 24 | 7 | 1 | 2 | .. | 35 |
| Specific situation | 3 | 36 | 11 | 4 | 1 | .. | 55 |
| General upset | .. | 3 | 3 | .. | 3 | 1 | 10 |
| Total | 4 | 63 | 21 | 5 | 6 | 1 | 100 |

Altogether these 100 clients made one hundred and fifty-four visits to the office. Sixty-seven were seen only once, but 63 of these 67 kept in touch with the Counsel for varying periods of time, through the use of the lending library, letters and telephone calls, special consultants and educational courses. The largest number of single visits fell in the pre-marital and specific-situation categories, clients in the group of those generally upset visiting the office more often in proportion to their total number.

The question may arise why four-fifths of the clients in this series visited the Marriage Counsel only once or twice for consultation, and limited their other use to letters, telephone calls, lending library, and so on. Was this because of pressure on them not to return for further consultation, due to explanation of agency function, or was it because, in the majority of instances, they got what they wanted in these one or two interviews and felt able to proceed independently?

The following considerations may throw some light on this question. As long as the counselor felt able, under agency function, to make the clients feel free to use the office in any way, the great majority of individuals seemed to make a natural and constructive use of the services in one or two interviews, plus the other uses already mentioned. Pressure for more interviews over a period of time came from the group described as generally upset.

In any agency in which service is offered through the medium of individual interviews, that which takes place between the client and the counselor is, in general, determined by the purpose, definition of function, and philosophy of the institution or agency and, in detail, by the way in which the

individual counselor handles the contact. Obviously this latter depends on the background and training of the counselors and is tremendously influenced by the knowledge and understanding of those factors in their own past and present experience which condition their attitudes toward the problems with which they are dealing, their philosophy of life, their ability to work with and help others—in short, by all those things which constitute their individual personalities and determine their relation to their profession. Obviously, again, any technique or approach used by a counselor, to be real and of full value, must pass beyond the stage of conscious technique. Only when a technique becomes enriched by the counselor's natural and instinctive way of working, and integrated with his or her individual personality, does its use become flexible and contain the possibility, even the probability, of great variation under difficult circumstances.

What one client responds to may completely inhibit the next. Some situations require a quick assumption of responsibility which may at first be quite terrifying; others demand the ability to let them alone. A few words or a phrase, with its accompanying expression and gestures, may tell you in one moment more of a client's background and attitude than pages of social history; for example, take the wife who says of her husband, "He hasn't bothered me that way [sexually] for a month"; the engaged girl who remarks, "I've been told all men are very passionate"; or the young man who looks you comfortably in the eye and states, "We Jewish people haven't the Puritan inheritance of taboos, fears, and guilts to prevent us from realizing to the utmost the completeness of passionate fulfillment. Our difficulties are apt to be more sociological in origin."

In interviews in the Marriage Counsel office, the counselor usually gets his lead from the client, using as a starting point the particular approach chosen by the man or woman in question. When guilts, fears, ignorance, and insecurities centering around many aspects of living arise, the significance of these can be recognized, in part at least. Through free and unforced discussion of a particular situation or, when this is indicated, of sexual relations in general, and through the reading of books, the client may be made to feel more free to

accept and do those things which he fundamentally—whether consciously or unconsciously—desires. In itself, the realization that other people think about these matters and have difficulties with them, that books are written about them, and that some individuals are willing and able to talk about them, removes much tenseness and brings these subjects into a more everyday light. To many people this fact in itself is a great relief.

The following material from the records illustrates the case-work treatment of clients and some of the differences in their ability or inability to use the help offered through the Marriage Counsel service. As we have seen, clients coming to the Counsel for individual interviews may be classified into three very general groups: those about to be married, wishing help and information to lessen the possibility of future difficulties; those needing assistance in a specific situation; and those whose difficulties may be very diffuse and involved (listed under "general upset").

The case that follows is typical of an encouraging type of pre-marital interview, in which the man and the girl seem to feel equal responsibility for the success of their relationship and are able to use comfortably, over a period of time, the service available to them through the Counsel. In many cases either the engaged man or the girl will come alone for a first visit, perhaps bringing the partner later, perhaps not.

*Case 1.*—The young woman in this case was about twenty-one, attractive, well-dressed, with a friendly and open manner. The young man was a few years older, nicely dressed, quiet, and somewhat diffident at first, gradually becoming very easy and friendly. They were both holding good positions.

They said that they expected to be married as soon as their finances would permit and wanted to get as much background and knowledge as possible in regard to the relationships involved. Asked whether they wished to talk to the counselor together, or one at a time, or both, the girl answered that as they had talked pretty frankly together already, she thought they would just as soon have the interview together. The girl did most of the questioning in the beginning, stating that a friend, a former client, had been to the Counsel before she was married and had suggested that the present client would find it helpful to come in. She said that she thought it might be a good thing if they read some books. A discussion followed about the background of the client and her financé and the particular subjects in which they were interested. They both wanted to understand the psychology as well as the physiology of the sexual side of marriage. The counselor talked for a while about attitudes

as influenced by our parents and their effect upon our feelings in the marriage relationship, about differences in the point of view of men and women, etc. The clients decided to borrow several books at intervals from the library.

The conversation then turned to the question of anatomy and childbirth and the possibility of physical examination before marriage. The young man became more actively interested, asking many direct questions, particularly in regard to the technique of contraception. To answer these the counselor used anatomical diagrams and described drugstore and clinic methods of birth control. This appeared to be a relief to him, and he volunteered the remark that he felt it would be a good thing for his fiancée and possibly for him to go to a physician before marriage. Both clients seemed anxious in regard to first intercourse and rupturing of the hymen, about which they had heard various alarming tales. Then they asked whether later on the counselor would give them the names of suitable physicians and whether they might return to borrow more books. They raised the question of payment, offering $2.00 and saying that they would like to pay more as they went along and could afford it. They returned the books after a few weeks.

A year later this young couple referred two friends of theirs, an engaged couple, who quoted them as saying that they had been helped so much by their interviews before marriage that they wanted their friends to talk with the counselor before they got married.

A month after that this client came into the office with her sister, who was to be married in two weeks. She said, "You helped me so much last year before I was married that I wanted my sister to be sure to talk with you before her wedding. I have not discussed anything with my sister, myself, as I thought it would be best for her to talk directly with you."

The client explained that she had not gone to see the doctor recommended until a week after her marriage, but had liked her very much. She looked well and happy. She smiled and laughed a great deal, spoke of her husband most affectionately, and in general gave the impression of a well-adjusted young woman.

Case 2 illustrates a somewhat different use of the Counsel's services where an individual, through group work given under the educational division, has been able to find help and to make active use of it.

*Case 2.*—The following letter was received in the Marriage Counsel office from Miss B., the client in this case:

"I guess you will remember me when I tell you I was one of your pupils in the 'Preparation for Marriage' class at the Y.W.C.A. last year. My name is ....., the girl with the red hair.

"I am writing for some information about birth control. Of course, I still remember what you taught me. I don't think any one could forget it, the way you explained it. I am going to get married. My boy friend's work is not so steady, but we have some hopes for steady work, so in the meantime, I will have to keep on working. We have been going together for seven years, so we decided we wouldn't wait any longer. We are going to take a chance, even though we haven't got all we want. I bless

you time and time again, because it is because of you and your work that it is possible for us to get married. I thank you from the bottom of my heart; in fact, we both thank you.''

This letter was answered by sending a list of doctors, with explanations as to the usual fee and times to go. A few days later Miss B. telephoned, explaining that she ''felt sort of queer'' about calling up the doctor herself. She wanted to go, but was nervous about it. She wondered if I'd mind awfully telephoning the doctor for her, and explaining the situation. She wanted to go to a woman physician, the one I thought best. I told her that I'd be glad to call, and suggested Dr. J., who was geographically near and had seen many engaged girls.

The following day a report came from the doctor that Miss B. had been at her office. She remarked that Miss B. was ''beautifully prepared, and told me that this was due to your most interesting and instructive lectures.''

The next case presents a client who, for some reason inherent in the situation or in herself, seemed to be extremely resistive to the help offered in response to her request and (so far as we know) unable to utilize our service.

*Case 3.*—Miss C. was a nicely dressed, healthy-looking young woman. She came to the office with an introductory letter from a professional, asking that she be given contraceptive advice, as she was to be married in a few days. After a few questions, to get some idea of a starting point suitable to this particular girl, the counselor attempted an anatomical explanation, with the use of charts, showing good and bad methods of contraception, and information as to where contraceptive appliances were available and the cost involved. Miss C. appeared much disappointed that the counselor didn't ''just have something here in the office'' to give her. After further discussion, she inquired what she owed and received an explanation as to how the service was supported. She thanked the counselor very perfunctorily and departed, remarking, ''I'll come in and bring you something next week.'' She was not heard from again, nor did she consult either of the physicians suggested.

The group of individuals who are already concerned about some specific situation may raise many different questions. They bring to the office a great deal of anxiety centering on the particular problem about which they ask help. The two following case summaries are typical of those who are anxious for help in specific problems and able to use it.

*Case 4.*—A woman of thirty, obviously advanced in pregnancy, arrived in the office. Although the elevator is only about twenty yards from the door, she appeared quite breathless. The lobes of her ears were bluish, her legs and ankles terribly swollen. Her whole appearance suggested cardiac involvement, plus extreme nervousness and exhaustion. She wished to be sterilized at the birth of her child, and asked help in achieving this. During the conversation I was able to suggest the advantage of regular monthly prenatal examinations. She admitted that she

had not been examined for a long time, and was glad to be referred, with a letter and report, to a prenatal clinic. There it was discovered that she had a heart condition, probably functional, but sufficiently severe to cause serious consideration of the advisability of interrupting the pregnancy before term. After receiving careful prenatal care, including hospitalization, she was subsequently delivered of a healthy baby. As physical abnormalities made it impossible for her to use modern methods of contraception, at her request and that of her husband, she was subsequently sterilized, through the coöperation of a specialist sponsoring the work of the Marriage Counsel.

*Case 5.*—A frail, sensitive, pitifully tense young woman was referred to the Marriage Counsel by a medical clinic. In her ten years of marriage she had produced with great difficulty five full-term babies, none of whom had lived more than a few weeks. Twice she had all but lost her life. After each delivery she was told by the physician in charge that, because of abnormalities, she should have no more babies. Since her husband had lost his job two years ago, they had wandered from town to town, eking out a meager existence. A progressive social worker had referred her six months ago to a birth-control clinic, where the doctor had told her that her anatomical condition made her a poor bet for modern methods of contraceptive technique. However, Mrs. E. had been successful for three long and happy months. Now, in spite of all her conscientious following of instructions, she was again pregnant, and desperately determined not to endure what was predestined to failure. She would gladly go to a good hospital—if not, whatever was available in the neighborhood. She asked to be sterilized. In spite of the suffering evident on her whole face, there was no whining, no bitterness, no loss of self-control. Her quiet courage and determination under the circumstances seemed amazing.

After explaining her situation, we were able to obtain the active coöperation of the head of the obstetrical service of a good city hospital, and the head maternity social worker. Mrs. E. was examined and found to have a heart condition warranting therapeutic abortion. By odd jobs she herself saved her registration fee of $5. Friends, interested in the Marriage Counsel, raised the remaining $25, to cover hospitalization. This was advanced as a loan, at Mrs. E.'s request. Mrs. E. was sterilized and convalesced well. A report from the physician stated that the conditions found at operation showed that she would again have been unable to produce a living child—would never have been able to. A few weeks later Mrs. E. wrote, "When I am able to go back to work, I will communicate with you to make a plan for repaying you. The financial support you gave me we can repay, but your kindness—never."

The third classification includes individuals with fairly diffuse involvement, who present a tremendous amount of anxiety. This may temporarily be concentrated on one problem, and, as some solution of that seems possible, be switched to something else. An upset person who has already been to various specialists, among whom are psychiatrists and psychologists, may occasionally, on learning that this service is

limited to short contacts on a fee basis, feel more free to make use of what we have to offer, and relate it to his or her own reality. Case 6, which follows, is an illustration of this use.

*Case 6.*—Mrs. G. was a college graduate of over thirty. She had always been rather unhappy and lonely. In spite of the fact that her seven years of marriage had been full of frustrations and difficulties, about which she had sought the help of many specialists, and that her husband was desirous of a separation, she came to the Marriage Counsel office, saying she did not want a divorce. At the end of the first interview Mrs. G. asked for an evaluation of the total situation. The counselor explained that she thought this was impossible without much greater study, and that she doubted if Mrs. G. was interested in making use of any such study, as she had already tried several experts. If she cared to find out details regarding the legal situation for a woman in her position, should her husband precipitate matters, we could talk this over with a reliable lawyer coöperating with the Counsel, and report to her. Mrs. G. appeared most desirous and appreciative of this. She was made to feel free to utilize the Counsel for help in specific situations as they might arise, and arrangements were made for some payment at each visit.

Over a period of a year Mrs. G. used the Counsel, limiting herself very definitely to the use that we had made available. She followed up the legal situation, getting a clear picture of that, read some books in the lending library, and then asked for a second interview, further to clarify her point of view, in order finally to reach her own decision. In all, Mrs. G. made five visits, the first three at monthly intervals, the last two about four months apart. She used these interviews to redefine her situation as it changed, to discuss attitudes about all of this, to test her own strength and independence. Between visits she occasionally utilized the office by letter and telephone, as a source of information about organization group work, specialists, and so forth.

By working on one phase of the total problem at a time, Mrs. G. seemed able at the end of a year to accept the fact which had been apparent to the experts whose advice she had sought before coming to our office—namely, that because of her own personality difficulties, and her husband's abnormalities, separation or divorce was an inevitable step in the solution of her marital situation. Her last message stated that this step was now being undertaken, and that she was standing it well.

Occasionally a very fearful, insecure individual, who would not go for psychiatric treatment because of anxiety in regard to any type of institution or medical procedure, may be able to use such an office as the Marriage Counsel, because the name and location are not connected consciously with pain. Case 7 is an instance of this.

*Case 7.*—Mrs. H. was an unhealthy-looking, stoop-shouldered girl of nineteen, with a dull and fearful manner. Her young husband of a few

months was working his way through a professional night school; her own family were now, and had been during her girlhood, in pitifully straitened circumstances. She had been referred to a maternal health center by a physician who had found her fainting on the sidewalk. When the doctor at the center had attempted the routine physical examination, Mrs. H. had been so terrified that no one could touch her. She was then referred to the Marriage Counsel with the statement that there was no physical reason why she might not become pregnant, which, it was felt, under the circumstances, would be nothing short of a calamity.

During the first interview, Mrs. H. expressed in words and manner such an absymal ignorance of the structure and functioning of her own body, such fear of physical pain, such tremendous insecurity, that after she left, the question of referring her for psychiatric treatment was discussed with a coöperating psychiatrist. The conclusion of the conference was that this girl would never have the nerve to go to a psychiatrist, and even if she would go, her whole background seemed so limited that it was doubtful if she could make much use of such a contact. It was agreed that we suggest to her a series of monthly visits to our office.

Over a period of six months Mrs. H. was seen four times, making and breaking as many additional appointments, keeping in touch occasionally between visits through letters and books. She used these interviews to discuss her anatomical ignorance, her fear of being hurt physically, and her worryings over their meager financial resources. Her remarks indicated repeatedly an almost complete rejection of her feminine rôle and the possibility of normal sexual relations. Again and again she would state that she didn't think she had a proper opening (vagina), that she couldn't find it with the mirror (suggested by us). Gradually, through a very slow assimilation of factual information, some lessening of fear was reached; and through the talking over with her of her fear of pain, some acceptance of its part in life for her and for every one was gained. At the end of five months Mrs. H. was able to go to the maternal health center. With the aid of an understanding physician to whom the counselor had explained the situation, she was examined and a beginning was made in teaching her contraceptive methods. The secretary reported, "Mrs. H. appeared so relieved she almost fell on our necks with gratitude." Two months later Mrs. H. wrote of great improvement in her husband's income, adding, "If my husband's income increases, I feel that I would prefer to have children."

The following case brings together in one situation the three categories used in classifying our cases. It shows the possible range of the Marriage Counsel service. The first interview is quoted almost in its entirety, as it illustrates fairly typically process and movement between clients and counselor. The remainder of the record is summarized:

*Case 8.*—The young couple in this case were to be married in the spring, and wished to talk things over beforehand. Miss M. was a rather short, healthy-looking young woman. She appeared relaxed and rather slow in reactivity. Mr. N. was a handsome, light-haired man, with a sensitive, rather dreamy expression. He might easily be withdrawn and

shy, but had a friendly smile. Both were dressed attractively and in good taste.

Miss M. appeared first by herself at the office. She said that she had been out to see her old friend, Mrs. J., to talk over the wedding preparations. At this time Mrs. J. had told her that she ought to come down to the Marriage Counsel, saying how much it had helped her. Two other of her good friends had been here. I said we were awfully glad when former clients felt like sending their friends. I asked Miss M. if there was anything special she wished to talk about, or whether she would rather wait until her fiancé came in. She said that she just wanted to talk over everything; she felt they were both terribly ignorant. I said that there was an awful lot that was new in getting to know a person so intimately, wasn't there? At which Miss M. colored slightly and said that she didn't know whether Mr. N. would like her to say it or not, but it did bother her some, as well as her fiancé, how easily he seemed to get aroused. She wondered if this was natural. She then explained that Mr. N. had never gone around with girls much. He'd worked hard all through college and did not feel he could take the time to think about marriage. She was the first girl he'd ever "gone steady" with. He'd never had any kind of sex experience. She really thought this was wonderful. I said that it certainly was unusual for a man of that age, and that it would seem only natural, if he had restrained himself so completely for such a long time, that he might be more than usually overwhelmed during the courtship period. That was certainly not unusual.

At this moment, Mr. N. himself knocked at the door and came in, looking rather abashed. Miss M. also looked uncomfortable. So I turned to Mr. N. and said that, while waiting for him, we had been discussing something of the whole question of what sex might mean to different people—of the fact that men and women might feel differently about it. I then went on to say that, of course, there was actually a physiological difference, also, between different individuals, depending to some degree on the glands of internal secretion. It was really true that some people were actually more highly sexed than others. One of the main adjustments between married people often depended on this very fact. It was very unusual for any two people to react in exactly the same way; therefore, there had to be some give and take on the part of each and some effort to understand what the other wished and to help to achieve this. Mr. N. looked increasingly interested. He seemed to forget to feel uncomfortable, and nodded once of twice, looking at me in a very direct way. He said there was so much to learn about all this, and he felt so ignorant. A friend of his had given him a book to read [he mentioned a certain book of sex instruction] and he had given it to his fiancée. He just couldn't realize that the things that book described happened between men and women. He was more mixed up than ever after he had read it. I said that the book he mentioned was one of the earliest written in this field, and that I thought it was pretty strong medicine, particularly to begin on. I used it in the office now only for particular situations, as I felt there were other, much better things to do. I then got out some books and explained the availability of the lending library.

Miss M. then said that it was important for them to know something about birth control. Because of their economic situation, they felt it wisest to postpone having children for a couple of years. I asked if

they wanted to discuss this now, at which they both looked very dubious. Mr. N. said he supposed they might as well talk about it. They could decide later whether they wanted to do anything about it, or not. I explained, with the use of charts, the methods used in the clinics, and spoke of drugstore methods. I mentioned the possibility of an unmarried girl's not being able to be fitted with a pessary because of the hymen, and explained the possibilities of having this stretched or cut in a doctor's office, adding that this is often not necessary. Mr. N. here said that it certainly was the greatest help to them to be able to talk this matter over. He wished he'd known there was a place like this long ago. He felt so lost. He thought it would be a good idea for his fiancée to go right away and see one of these doctors. It sounded like the best thing to do, less psychologically difficult than other methods. As for him, he'd never had a condom in his hand, and didn't know whether he could manage one or not. Miss M. appeared a little less sure of wanting to go ahead so fast, and I remarked that perhaps they'd like to think it over. They could make an appointment direct, or through this office, at any time. After some discussion, they asked me if I would be willing to call up a doctor while they were there. We discussed arrangements about the fee for the doctor, and they finally chose Dr. S., as geographically convenient. I then telephoned Dr. S. and at their request made an appointment with her for them for the following afternoon, after explaining that they were to be married in a couple of weeks.

Both Miss M. and Mr. N. said that they would like to read the books suggested, and Miss M. said she felt that, after going over these, they might want to talk again with me, if possible. She felt that they might know more definitely what they wanted to talk about. I said that perhaps they would find that the books themselves answered some of their questions, but if they still wished to talk with me, I should be very glad to arrange it. Mr. N. said that he understood some contribution to the Counsel was customary, and after some discussion, they asked if $2.00 was suitable. They also left $1.50 deposit for the books, which was to be refunded upon the return of the books.

I wondered somewhat about these two young people. The girl's general physical appearance was somewhat suggestive of some very slight deviation of sex hormones. This seemed borne out by her mentioning several times that she didn't seem to be as much aroused, or aroused as easily, as her fiancé. I wondered also about Mr. N. A history with such a lack of interest in sex, for such a period of time, if the girl's story was true, is certainly unusual. It seemed to me there might be certain guilts and suppressions, which, with the combination suggested by the girl's appearance, might possibly make difficulties. However, there was also the possibility that this might all adjust itself normally.

Before leaving, Mr. N. said that he wondered how you could know when you were having too much sex life. What would the signs or symptoms be? Miss M. added, "Yes, what is the usual amount of intercourse among married people?" I said that, of course, there was a great variation. From our discussion, they could realize that what was normal for one person might not be for another. Some couples had relations once or twice in twenty-four hours when they were first married. Later on there might be a variation from once a night to once a month. Feelings of fatigue and strain were often one of the first signs that you

were pushing things a bit too far. If you felt well, and were able to go about your business in the usual manner, there was really no need to worry. Another thing worth thinking about was that neither partner would wish to push the other to the point where he or she might become upset or disgusted.

A few days later Dr. S. told me that upon examination Miss M. was found to be pregnant, although her hymen was intact. She had explained that once and once only her fiancé had lost control of himself and deposited semen on the outside of her body. Dr. S. was bothered by this situation as she felt that the young couple would get off to a bad start, with meager finances and a full-term baby born in a small town after seven months of marriage, which would mean gossip and criticism among professional associates. As they had not asked anything further, Dr. S. felt that she could discuss no alternative to having the baby. I agreed with Dr. S. and mentioned my worries over the accumulation of fear and distrust with regard to the whole question of sex which the situation would precipitate in individuals already presenting somewhat unusual attitudes and experiences.

A couple of weeks later Miss M. made another office appointment, to which both young people came. Although they had been married in the interim, they both looked dejected and miserable. Mrs. N. was feeling very unwell and described the typical distress of early pregnancy. Mr. N. was apologetic and self-derogatory. A most unfortunate attitude of censorship and the acceptance of guilt seemed to have grown up. There had been no satisfactory sex experience since marriage. We discussed this, its possible cause, and made suggestion to lessen the difficulties for the future. They then raised the question of interruption of pregnancy, the details of which we discussed. They felt that they would decide nothing until the holiday season. I emphasized the importance of considering their own feelings about the whole situation, toward each other and toward themselves.

A week later Mrs. N. came in alone, saying that she had made up her mind to do something about this. She looked miserable and said that she could not go through with the pregnancy. Her husband was agreeable to anything she decided upon. After a good deal of discussion of the dangers involved, I suggested checking with a medical opinion. Mrs. N. talked to Dr. S. from the office and was told that it was too late to do anything without real risk. She appeared depressed and left, I thought slightly relieved, after further talk about babies, saying that she guessed she would have to go through with it. My feeling was that no matter whether Mr. and Mrs. N. decided to have this child or not, they were going to have a good many adjustments to face. I mentioned the possibility of their using the Counsel to discuss anything they wanted when they felt so inclined.

About ten weeks later Mrs. N. made another appointment, coming in wreathed in smiles and radiating good health. She wanted me to know that in spite of the difficulties involved, she and her husband, after further consultation with her mother, had decided to take steps to relieve the situation. Mrs. N. told me in detail the treatment and convalescence that she had undergone. There were no complications, her menses having now been regular for two months. They were so relieved and happy and were very comfortably settled in their own home. Mrs. N. again asked

several questions about frequency of sexual relations, mentioning that they had refrained for some time because of her condition. Now she would be fitted with an adequate contraceptive device and hoped that gradually a satisfactory adjustment would be worked out. She felt pretty sure that in about six months they would want to have a baby.

The case material just given illustrates all three of the categories under which we have grouped our cases. Cases 1, 2, and 3 represent various uses made by clients of the premarital interim work; Cases 4 and 5 variations under the category "Specific Situations"; Cases 6 and 7, ways in which generally upset individuals have been able to make use of help in the manner in which it is limited by our agency definition of function. Case 8 gives a rounded picture in which all three divisions are represented. This last case, with the detailed quotations from the first interview, illustrates in a way fairly typical for this Marriage Counsel process and movement between client and counselor. It also serves as a rather striking example of what may happen when a client presents a very general and diffuse problem on which, because of agency function, he is able to start working in limited areas only. In Case 8, the total problem seemed overwhelming and was untouched. By making clear to these young people the areas in which the Counsel could and could not assist, they were able to define their own difficulties and use the agency in first one and then other specific areas as they became ready and able to accept help. This serves, then, to show how agency function, when defined and understood, may become a clarifying process for the client, enabling him to proceed with the solution of those problems in which, because of their great diffuseness, he had been blocked.

These particular cases, picked from the three general groups, are suggestive of the kinds of use made of the service by 100 consecutive clients. They are also suggestive of the differences shown by individual clients in their ability to utilize what is offered. The relation of the use made of an agency by the clients to the agency's definition of purpose and function is an indication of the place that such a service has, or should have, in a community. If the service is utilized, and the use made falls for the most part within the agency's definition of function, without duplicating or overlapping the services offered by other organizations in the community,

there would seem to be a legitimate place for such a service. On the contrary, opposite results would seem to indicate a redefining of purpose and function, to meet a need expressed by intake, a coördination or merging with one or more agencies in allied fields, or complete cessation of activities. With these issues in mind, what conclusions can be drawn from this analysis of 100 consecutive cases seen by the Marriage Counsel during its third year of existence?

Our data seem to justify the belief that a short-contact service, with no obligating follow-up, may have something to do with enabling prospective clients to utilize the service offered more freely. How far the low percentage of cases referred under pressure is tied up to the small number of cases referred by agencies is hard to estimate. But the bearing that the referring of a case has on the client's use of an agency is worth considering. There is, so far as we now know, no other agency in this community definitely limiting the greater part of its work to short contacts in a fairly clearly defined and limited area of work with young, so-called normal, individuals. There are several agencies and institutions dealing with numerous phases of family adjustment, and various psychiatric services available for the obviously abnormal. That two-thirds of a group of 100 consecutive clients were seen only once, but that 63 out of this number had further contact with the office by telephone, letter, use of lending library, or reports from coöperating specialists, seems to indicate a legitimate place for the short-contact service. That 21 of the remaining one-third were seen only twice and that only 12 of the total 100 were seen three or more times presents additional evidence.

Further contact with three-fourths of its clients would be considered a high proportion for an agency in which routine follow-up or home visiting is undertaken. That further contact and, in the majority of cases, indication of utilization of available service should have occurred in an agency in which no routine follow-up is undertaken, except through coöperating specialists, raises interesting questions as to the releasing possibilities contained for the individual in knowing that he is as free to go as to come—as to the effect that a service

limited to short contact may have upon the client's ability to use it.

Two-thirds of the 100 clients were under thirty years of age and half were either engaged or had been married less than five years. This seems to indicate that the service is being used by young people, in the majority of instances, in a preventive capacity. About 18 per cent of the cases were from the group classified as general upsets and from those who presented specific problems, but were really generally involved. These clients brought to the Counsel conditions that seemed to indicate a need for longer contact and that make it necessary to consider the question how many cases from this group should be accepted under the present definition of function. It does seem that there are other agencies in the community equally or better equipped to offer services to these last mentioned individuals, if arrangement for referring them could be made.

The whole question of referring a case after an initial interview has taken place is too complicated to discuss in detail in this study. It can only be mentioned here that it is no easy matter to determine how deeply some individuals are involved without one or two interviews, and that these interviews in themselves may start something which may inhibit the client from using another agency. The importance to any institution or agency, and the difficulty, of initial diagnosis in applications and first interviews can also only be mentioned. If this is to be even partially adequate, it would seem necessary that the worker who handles it not only should be able to size up an individual in a short time, but also should have a very thoughtful understanding of agency purpose and function in its relation to intake.

Because there are already other agencies equipped to handle problems of family adjustment on a long-time basis, it would seem that the group of "generally upset" individuals should remain a small part of the total work of the Marriage Counsel and should be limited in their use of this service. It also seems as if certain of the specific situations could eventually be handled by medical social service. Because the Marriage Counsel is unique in its emphasis on preventive work with young people on a short-contact basis, this group should

largely predominate. In this study the relation between intake, use made of service, and definition of function has been found to be sufficiently close (within the limits of an experimental period) to warrant the conclusion that the Marriage Counsel is offering, on a small scale, service for which a community need has been expressed and which, during three years of existence, the Counsel has been utilized to meet. The steady increase in the demands for its services, with no effort to publicize its existence, indicates the possibilities of future growth and service.

# MARITAL HAPPINESS IN TWO GENERATIONS

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MARITAL happiness is commonly supposed to be associated with childhood experiences and family background, but evidence on this point is scanty. To throw more light on it, therefore, the face sheet used with family-adjustment clients of the Los Angeles Institute of Family Relations includes a rating of the family background of husband and wife, separately, as "superior," "normal," or "unhappy." The rating depends on the client's own statements, so there are as many bases of judgment as there are clients; but no other basis of rating is possible in this instance.

A series of 377 records has been tabulated, in an effort to find out what proportion of clients (all in this series unhappy in their own marriages) are the offspring of parents who were themselves unhappy in marriage. The results were as follows:

| | *Per cent superior* | *Per cent normal* | *Per cent unhappy* |
|---|---|---|---|
| Man's parents..... | 7.4 | 48.0 | 44.6 |
| Woman's parents..... | 6.4 | 48.5 | 45.1 |

It appears, therefore, that not far from one-half of these unhappy husbands and wives are the offspring of unhappy marriages, the figures for men and for women being virtually the same.

Is there a tendency on the part of these clients to misrepresent their parental backgrounds, intentionally or unintentionally? It has sometimes been supposed that persons unhappily married would tend to look back at the parental home through a sentimental mist and to idealize it. There is nothing in these figures to suggest the presence of such an influence. If there is any "halo effect," the percentages suggest that it is negative rather than positive. But the detailed

descriptions of the parental home which the clients give leave no doubt, in our own minds at least, that their judgments are reasonably objective.

As a control, about 2,000 marriages were tabulated by graduate students in adult-education classes at the University of Southern California. Students were instructed to list only marriages in the educated part of the population and of at least five years' duration. Most of these represent their own relatives and close friends, since they would not otherwise have the necessary information as to the happiness in marriage, either of the husband and wife or of the parents of the husband and wife.[1] They were instructed to rate all marriages as "happy," "doubtful," or "unhappy." The data were tabulated as follows:

*Marriage of man's parents*

| *Marriage of man* | Total No. | % | Happy No. | Doubtful No. | Unhappy No. |
|---|---|---|---|---|---|
| Happy | 1,219 | 58 | 886 | 153 | 180 |
| Doubtful | 304 | 15 | 131 | 119 | 54 |
| Unhappy | 557 | 27 | 276 | 78 | 203 |
| Total | 2,080 | 100 | 1,293 (62%) | 350 (17%) | 437 (21%) |

*Marriage of woman's parents*

| *Marriage of woman* | Total No. | % | Happy No. | Doubtful No. | Unhappy No. |
|---|---|---|---|---|---|
| Happy | 1,271 | 58 | 899 | 138 | 234 |
| Doubtful | 324 | 15 | 160 | 115 | 49 |
| Unhappy | 581 | 27 | 283 | 106 | 192 |
| Total | 2,176 | 100 | 1,342 (61%) | 359 (17%) | 475 (22%) |

Those classed as definitely unhappy should be fairly comparable with the clients of the Institute of Family Relations. It appears that 203, or 36 per cent, of the 557 husbands and 192, or 33 per cent, of the 581 wives in the unhappy group had parents who were described as definitely unhappy—a percentage lower than that for the Institute's clients. If, however, we calculate the percentage of unhappy couples who came from homes either unhappy or doubtful, the figure is raised to 50 per cent, slightly higher than that for the Insti-

[1] In nearly a hundred instances my informants knew the background of the wife, but not of the husband. Hence the discrepancy between the number of men and that of the women. This discrepancy should not affect the validity of the conclusions.

tute's clients. In general, the conclusions from the two sets of data are similar. A large proportion of the unhappily married persons in the community come from unhappy childhood homes.

To judge the significance of this fact, one must know also how many happily married persons come from unhappy homes. The Institute's data throw no light on this point, since all the clients in this series are unhappily married. But the data contributed by students at University College, U. S. C., furnish an unequivocal answer. Again there is no statistical significance between percentages for husbands and wives, but we give them separately as a matter of information:

Of 1,219 men happy in marriage, 180, or 15 per cent, came from unhappy homes as contrasted with the 36 per cent of unhappy husbands who came from unhappy homes.

Of 1,271 women happy in marriage, 234, or 18 per cent, came from unhappy homes, as contrasted with the 33 per cent of unhappy wives who came from unhappy homes.

The comparison seems to leave no doubt that there is a "tradition" of marital happiness—that it is passed on from one generation to the next. The findings should be fairly representative of conditions in the educated part of the white American population. While the data were gathered in California, many of the marriages of this generation, and most of those in the previous generation, occurred in other states.

The advantage of the happy parental home may be seen by calculating the percentages in another column of the table. Of the 1,219 men happy in marriage, 886, or 73 per cent, came from happy homes; of the 557 men unhappy in marriage, 276, or 49 per cent, came from happy homes. The findings are almost identical for the other sex: of 1,271 women happy in marriage, 899, or 70 per cent, came from happy homes; of 581 women unhappy in marriage, 283, or 49 per cent came from happy homes. Or to combine the two sexes in still another calculation, 2,635 happy homes produced 67 per cent of happy marriages, while 1,621 unhappy homes produced 43 per cent of happy marriages. The advantage of the happy home is more than half again as great as that of the unhappy home so far as concerns the children's chance of making a success of their own marriages in the future.

The data likewise suggest that there has been no marked change in the happiness of marriage in the last generation. In this unselected group, 58 per cent of the marriages were happy; among the parents, 61 per cent. There has of course been an unintentional, but inevitable selection of parental marriages, since childless marriages are not represented among them. Happiness in marriage is correlated with the presence of (and also with the number of) children; hence the inclusion of childless marriages (about 20 per cent of the total) in the filial generation increases the percentages of unhappy marriages in the filial generation. If these childless marriages were eliminated from the younger group, the percentage of happiness would certainly be raised to that of the parents, if not higher.

The conclusion that happy marriages "run in families" was reached by Lewis M. Terman and Paul Buttenwieser, who selected 98 couples as above the average in happiness and 97 below the average and had these couples rate the happiness of their parents.[1] They recognized five grades: very happy, happy, average, unhappy, and very unhappy. The results are, therefore, not directly comparable with ours, but they are suggestive, in spite of the small number of cases. Their group of "very happy" parents ought to be fairly comparable with the "superior" group of the Institute face sheet, but the percentages are very different. The Institute's clients (all unhappy) ranked only 7 per cent of their parents' homes as superior. Terman's unhappy subjects put 19 per cent of their parents in the highest category; his happy subjects, 30 per cent. His subjects, therefore, took a much more favorable view of their parents than did the Institute's clients. The fact that even his unhappy subjects were probably not so unhappy as the Institute's clients may help to explain the discrepancy.

Without striving for too great accuracy of interpretation where so much depends on individual judgments, one must at least recognize that these three studies point in the same direction, and leave no doubt that happiness runs in some families, unhappiness in others.

[1] "Personality Factors in Marital Incompatibility," by Lewis M. Terman and Paul Buttenwieser. *Journal of Social Psychology*, Vol. 6, pp. 143–71, May, 1935.

What is the explanation? "The reader will make his own choice between a biological and a sociological explanation," Terman and Buttenwieser remark. Perhaps the eclectic reader will be able to take a little of each.

Mental-hygienists will hardly question that parental patterns and childhood attitudes have some effect in creating the individual's own patterns later in life. But the unfavorable results of an unhappy family background may be somewhat reduced by compensation. Sometimes a young man or woman comes to the Institute for its pre-marital service—an education for marriage. "My own parents were so unhappy together," the client explains, "that I made up my mind I would never let my own marriage get into such shape—that I would leave no stone unturned to prevent it. So I have come to you to get all the help available to prevent my own marriage from being like that of my parents." It is not yet possible to say, statistically, how far such ideals can be realized, but it seems probable that in some cases this compensatory mechanism serves to diminish the resemblance between parent and child in respect to marital unhappiness.

While "psychic infection" is generally accepted as a factor in the transmission of marital unhappiness, and the explanation seems to be sustained by clinical experience, the biological factor cannot be excluded. The biological inferiority of divorcées has been described frequently.[1] On the whole, they show two or three times as much commitment for insanity, conviction of crime, and tendency to suicide as do the happily married, and they have a much shorter expectation of life. These differences (together with their high degree of childlessness[2]) certainly have a biological basis in some instances; and if such is the case with unhappily married persons who go through the divorce court, it may be true to some extent for unhappily married persons who do not go into court. Since the constitutional bases of mental disease and physical health are to some extent inherited, it would

[1] "Divorce and Remarriage From a Eugenic Point of View," by Paul Popenoe (*Social Forces*, Vol. 12, pp. 48–50, October, 1933). See also "Divorce as a Biologist Views It," by Paul Popenoe. *Marriage Hygiene*, Vol. 1, pp. 247–53, February, 1935.

[2] "The Fertility of Divorcées," by Paul Popenoe. *Journal of Heredity*, Vol. 27, pp. 166–69, April, 1936.

logically follow that some of the offspring of inferior and unhappily married persons would inherit their parents' inferiority and make a bad record in matrimony because of it.

A reasonable conclusion seems to us to be that the existence of marital unhappiness in a family is due, in many instances, to the interacting influences of bad heredity and bad environment.

## SUMMARY

1. Of 754 unhappy husbands and wives who consulted the Los Angeles Institute of Family Relations, about 45 per cent came from family backgrounds described as unhappy.

2. This percentage is one-third higher than that found for 1,138 unhappily married persons in an educated group of controls.

3. Of 1,219 happily married men in the control group, only 15 per cent came from unhappy homes.

4. Of 1,271 happily married women in the control group, only 18 per cent came from unhappy homes.

5. There is a marked relationship between being brought up in a happy home and being able to live successfully in marriage in adult life.

6. Of the marriages of 2,635 young people from happy homes, 67 per cent turned out happily.

7. Of the marriages of 1,621 young people from unhappy homes, 43 per cent turned out happily.

8. Both biological and educational factors are probably involved in this result.

# "FACING REALITY" IN FAMILY LIFE*

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IT is presumptuous for a layman to discuss the topic "Facing Reality in Family Life," especially when there are so many in this audience who are professionally competent and interested in this subject and could deal adequately with it. I can only hope you will bear with me patiently, and permit me to express some of my personal reflections and perplexities. Needless to say, I cannot, if I would, offer you any pronouncement or attempt any critique of this subject. Let me emphasize that I wish to *discuss* the topic, not to *debate* it, and that I am not venturing any criticism, explicit or implicit, of persons or theories. I am forced to make this long preamble and explanation because it is so difficult to speak in public on any subject without being interpreted in terms of the "fight image." Public audiences apparently enjoy conflict so much that they insist upon translating every remark into an attack. We all know how an innocent suggestion of amendment in a theory is immediately headlined as "Dr. X flays such and such theory."

To begin, then, on the topic, the phrase "facing reality" (which I have put in quotes to indicate my unauthorized lay use of the term) has a definite professional meaning and use. Psychotherapists have made us familiar with the phrase both as a description and as an exhortation. To face reality, as they have made clear, is to accept one's own limitations and defects and likewise to accept the limitations and defects in others; to relinquish or avoid the many practices by which we evade responsibilities and fumble opportunities, by which we seek solace in phantasy and daydreams, by which we distort the circumstances of our lives to the detriment of our own mental health and often with gross injustice to others. It also means recognizing and accepting social control of life. The

* Read before the biennial meeting of the National Council of Parent Education, Chicago, Illinois, November 14, 1936.

reality principle is one of the cardinal points in modern psychotherapy. As such, it gives the basis for the use of the phrase "facing reality" as an exhortation to the individual who may be disposed toward the escapes, evasions, and distortions that may lead to serious mental disorders.

There is no need in this audience to elaborate this brief statement. I am making it merely to indicate clearly that there is a legitimate professional meaning and use for the phrase, which, I assume, we will all endorse. Recently, however, the phrase "facing reality" is coming into wider use in the fields of social work, parent education, counseling and guidance, and in education. It is this extension of the phrase that has prompted me to discuss the topic here and to propose two questions. When we ask an individual to face reality, may we ask, "Whose reality?" and, "How do you face it?" I am not asking these questions as a prelude to a metaphysical discussion (not even in Chicago), nor as an excuse for delivering a personal definition and formula for living. Quite the contrary. I am raising these questions because I am genuinely perplexed and would like to expose the grounds for my perplexity here, since I believe that the members of this audience must undoubtedly share some of my confusion in this area.

Let me approach this subject obliquely by asking you to consider the situation in this light: We all *exist* in a public world, with plants and animals, machines, processes, and other individuals, which, by various and sundry instruments and devices, we can locate and measure as part of this public world. But it is so obvious as to be almost a truism that each of us *lives* in his own private world, in the sense that each of us sees this public world with a different perspective, assigns to its various elements different meanings and values, and reacts to them with feelings that are peculiarly his own. Not the least significant aspect of this curious situation is that each one of us can and does live both in the public world, to the extent that we share certain common meanings and values necessary for living in a group, and at the same time in this private world of peculiarly individual meanings and values that constitute what Sapir and others have called our "subculture." We can achieve this really extraordinary feat of

accommodation because of our unusual elasticity, and because the society in which we live tolerates a large measure of divergence from the precise, socially sanctioned patterns of use and wont. Nevertheless, we are forced continually to realize that in a given situation all persons present are responding in a highly idiomatic manner to what appears to be a common, public, objective life situation, but actually is only a screen, so to speak, upon which they have projected their own meanings, significances, and values. Right at this moment, while I am speaking, using our common language, each one of you is hearing a different speech, deriving different connotations and implications, giving my words peculiar emphases, and seeing me in a context of which I am wholly unaware.

If, then, I ask the question "Whose reality?" you will see that I am not indulging in any captious or facetious mood, but rather am attempting to bring out into open discussion this truly remarkable aspect of human life, the implications of which for family life seem, to me at least, to be far-reaching. When we adjure an individual to face reality and then ask ourselves whose or what reality we have in mind, we cannot, as in earlier years or in many other cultures, cite an accepted body of ideas, beliefs, morals, ethics, patterns of behavior, that stand as the time-sanctioned wisdom of life by which the individual may guide his conduct and find resolution of his conflicting needs and impulses. Such common realities as our grandparents and great-grandparents shared had this solid foundation of venerable conceptions about the universe, man's place therein, his duties and responsibilities as a member of the group, his rôles in the family, and a conception of the self that served as a matrix for his personality. We to-day can look back wistfully to that time when, despite privation and hardship, our pioneer ancestors could face life with fortitude and with the conviction that there were realities about which no one had doubt.

But to-day there is no such common body of ideas, conceptions, and beliefs, nor a generally accepted hierarchy of values with which the individual, however much he lives in the private world of his sub-culture, can check and correct any undue deviations from a socially approved norm. The old certain-

ties and the old aspirations that created the reality of our predecessors cannot be reinstated by any effort of will or devotion. And as we realize this, we must face a life for which we can find little guidance, little certainty, and few sanctions. Indeed, it is almost as if, for the first time, man *did* face reality in the sense of an objective, unadorned, and unvalued world and life. The cumulative scepticism and disillusionment of many centuries has brought us to the stage where we have little to believe in and little to hope for; because, as individuals, we cannot, save for a few rare personalities or geniuses, create our own values, meanings, and significances, nor construct a design for living that is humanly and socially desirable.

Men and women to-day, it may be said without exaggeration, are destroying themselves because they have no clear guidance to the rôles that they should play as husbands and wives, as fathers and mothers to children. Men do not know what kind of women they want to marry, and women do not know how to clarify and to integrate their conflicting needs and loyalties into a coherent feminine rôle compatible with the necessities and the opportunities of the time.

"Man lives more in anticipation than in realization," and probably the conception of himself and of the kind of person he would be is of more importance individually and socially than almost any other phase of his life. How, then, can individuals construct ego-ideals that will enable them to live sanely and wholesomely, when there are no socially sanctioned and coherent patterns or designs for living in our culture to guide the individual in the construction of such ego-ideals?

Here we must pause to remind ourselves that the enduring and persistent human needs and aspirations have not been destroyed or changed. Rather it is the cultural patterns in and through which fulfillment is sought which have been largely destroyed and thus far have not been replaced.

When we exhort an individual, man or woman, to face reality—whose reality shall be faced?

Have we individually found the answer to this immense social need, and are we prepared, therefore, to give guidance to others? Or do we expect the harassed and perplexed individual somehow to create for himself or herself a private

world of realities that *will* be adequate in the present-day social situation? When we ask people to be "objective," do we really want them to strip off from life all the values, the aspirations, the emotionally toned beliefs and longings that give life meaning or significance? Can any of us tolerate objectivity except in those specialized and secluded activities in which, for the moment, we put aside the burdens of our personal life (so far as possible) and address ourselves to some fragment of the world or of literature in the pursuit of scientific or scholarly distinction? As Edward Sapir so clearly pointed out, man is so constituted that he cannot face his organic necessities and functions objectively. Indeed, the frequent cry for objectivity may be but an excuse for evading the more pressing problem of what *values* we are to seek in our individual lives and in our social life. For if we will but reflect on our own life experiences, we will see that objectivity in any rigorous sense must mean a renunciation of almost all that we live by and for. Even those we love most dearly cannot stand the test of too exacting an objectivity nor could any of us, immersed in a constant struggle to attain to being the kind of persons we should like to be, really undergo the test of objectivity in the eyes of our family and our intimate friends. We turn to them because they are *not* objective; rather they are compassionate and understanding and forgiving of our all too frequent failures to live up to our own aspirations.

Doesn't this, then, point very directly to a conception of the family, more especially of marriage and family life, as both an opportunity and an urgent occasion for the giving and receiving of the affection and the understanding and the intimacy that each one of us so acutely needs, especially to-day when we do have to face objective demands of occupations and of the many and varied social, governmental, economic, and other pursuits? And if the family is to be a relationship between adults and children that fulfills some of these urgent needs, then the *reality* that men and women must face in the family life of to-day and to-morrow is not *pure objectivity* or an unadorned, affectless way of living, but rather an aspiration, a hope, a body of values and a core of feelings that cannot be clearly defined or stated to-day because our culture has

not yet reached that stage, but toward which those living to-day must somehow, somewhere, gropingly strive.

At this point we should digress by recognizing what a burden we are inclined to lay upon others when we exhort them to face reality and imply that they must learn to "take it." Can we honestly tell people that our present disorderly and conflicting culture, with all the frustration and distortion it imposes on individual lives, is the reality that we want them to accept and adjust to, and do we wish to convince them that their own personal frustrations, anxieties, and unfulfilled needs are necessarily due to personal inadequacies and failure to face reality? It is hard to believe that any one who reflects upon what our cultural confusion is doing to individuals can really be unaware of the implications of such advice.[1] It is true, as the studies of comparative culture show, that men can cheerfully and wholesomely conform to almost any rules of conduct, however much they appear to limit and distort the pattern of life. But in those cultures there is always a body of beliefs and sanctions that reinforces the individual and helps him to "take it"; whereas to-day the individual is exposed not only to conflict and confusion in our culture, but to the absence of any profound convictions and beliefs that will make his individual frustrations and renunciations bearable.

What, then, are we to say to the families which we are endeavoring to counsel and guide, as they fumble for a design for living? After we have given them some understanding, if possible, of what "facing reality" means in the original sense we discussed in the beginning, how shall we go on to clarify for them the cultural realities they have to face, and how shall we tell them to face them? Should we yield to our nostalgia for the good old days when men and women knew what they wanted and what they were supposed to do, and therefore exhort others to seek a reinstatement of the old family pattern? Should we, on the other hand, expose the poverty of our ideals and values and invite a return of the post-war attitude toward life? Or should we be bold enough to confess that we do not know what reality is, since it must

[1] See "Society as the Patient," by Lawrence K. Frank. *American Journal of Sociology*, Vol. 42, pp. 335–44, November, 1936.

always be an aspiration, a hope, an anticipation for which men and women will strive, trusting to secure some fulfillment of their needs, some realization of their values, and some assuagement of that inescapable loneliness that haunts their lives? Must not the realities of human life always be presented in a time-perspective that shapes the dimensions of our values? And is not our task to-day to help one another—because we cannot do it alone—to realize that we can *face* reality only by boldly attempting to *create* reality? In doing this, as in every attempt at creation, we must run the risk of failure. But no risks are great enough to block the human need for aspiration and striving. The clue to this, I think, has been suggested by Kurt Lewin, who has shown that there must be in the individual an uninterrupted and free flow between the plane of reality and the plane of unreality, and that to the extent to which the individual's plane of unreality —call it phantasy, imagination, hopes—is restricted, his capacities for dealing with the actual world around him are by so much limited.

If the foregoing has any meaning and points to any conclusions, it must suggest, I believe, that in our efforts to guide youth toward marriage and family life, and to counsel men and women who are already married, we must somehow recognize how contingent and precarious our lives are to-day, how desperately we need values and goals to which we can orient our lives, and how much the individual man and woman, by the quality of their lives and the design for their living, are directly contributing to the creation of the reality that will, we hope, some day emerge for the guidance of our children or our children's children. For each decision made to-day is, as it were, an act of creation of the new culture, whenever men and women courageously and affectionately attempt to build a relationship in marriage and in parenthood that fosters human values and human fulfillments. Too long has human life been sacrificed to supposed necessities that have been sanctioned as realities by those who would impose upon others their own distortions and frustrations. It may be the great distinction of this age that, instead of *facing* reality, it began to *create* reality within the family.

# HOW MUCH DO TEACHERS KNOW ABOUT MENTAL HYGIENE?*

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SINCE the idea was given impetus by Clifford Beers, mental hygiene has increasingly demanded the attention of psychologists, educators, and the laity in general. It is hardly necessary to stress the importance of this topic to teachers. (Authorities maintain that the roots of mental ill health are often found in childhood.) Frankwood Williams has stated that there are to-day in the public schools of this country one million children who will later become inmates of insane asylums.[1] Lawrence Averill has expressed the opinion: "The educational leadership needs, more than anything I can think of, to sit for a time at the feet of the mental-hygienists and learn of them the tremendous rôle played in our lives by mental attitudes."[2] If teachers apply the underlying principles of mental hygiene in their contacts with children, it is believed that they can do much to lay the foundations of good mental health.

The purpose of the study reported here, which was conducted under the direction of Dr. C. W. Telford, head of the Department of Psychology of the University of North Dakota, was to discover how well teachers know the most important principles of mental hygiene as it applies to children. No attempt was made to determine how well teachers apply these principles in their contacts with children. Presumably knowledge precedes practice. A teacher would not be likely to apply a mental-hygiene principle correctly when

* Based on an unpublished study in the library of the University of North Dakota, Grand Forks, North Dakota.

[1] Quoted by Dr. Donald B. Armstrong in "Immediate Opportunities in Child Health Conservation." *American Journal of Public Health*, Vol. 16, June, 1926. p. 583.

[2] "*Directing the Activities of the Classroom toward a Mental-Health Objective,*" by Lawrence A. Averill. MENTAL HYGIENE, Vol. 19, October, 1935. p. 533.

she had a wrong concept of it, although it is conceivable that she might have a correct concept, yet fail to apply it correctly.

Questions of minor importance were also considered, such as: "Have experienced teachers a better knowledge of mental hygiene than inexperienced teachers?" "Do teachers in large schools, small schools, and rural schools differ in knowledge of mental hygiene?" "Do teachers trained in different types of institution differ in mental-hygiene knowledge?" "How well do supervisors in charge of training teachers know the underlying principles of mental hygiene?" "How well do students preparing to teach know these principles?" "Is there any relationship between knowledge in mental hygiene and scholarship?"

In order to secure a list of the underlying principles of mental hygiene, a large number of periodicals, psychology texts, and mental-hygiene texts were studied. Principles were listed as they were actually stated or as they could be obviously inferred from the context. A list of 160 principles was thus finally compiled. In order to determine the validity of this list, it was decided to consult the opinion of experts. This was done indirectly when the principles were selected, since they were taken from recent writings in the field. It was done directly by sending the list to twelve individuals now working in mental hygiene. Of this group, two were working in the field of psychiatry, six were connected with child-guidance clinics, and four were instructors in psychology and mental hygiene in higher institutions. These judges were asked to rate the principles on a six-point scale, using as a basis the importance of the principle to teachers of children. If they considered the principle to be of the utmost importance, they rated it 1; if it was of slightly less importance, they rated it 2; and so on. Principles of little or no importance were rated 5, and principles considered to be false were rated 6. The ratings were then tabulated, those statements having the lowest totals being considered as most important in the opinions of the judges.[1] A list of the 57 principles ranked as most important by the judges was formulated, and

[1] The mean and the standard deviation for each statement were included to give a weighted measure of its importance.

this, by a procedure to be described later, was reduced to a final list of 42.

As might be expected, on some statements there was a wide range of opinion. There was a high rate of agreement, however, on the 42 statements finally selected as the most important. Eleven of the twelve judges rated 29 of the statements 1 or 2. On the 42 statements, the judges were 88 per cent in agreement that the statements were important for teachers to know.

In the list of principles given below, the numbers following each statement indicate the number of judges who rated that principle 1, 2, 3, or 4.

| *Final list of principles* | *Number of judges rating the principle* | | | |
|---|---|---|---|---|
| | *1* | *2* | *3* | *4* |
| 1. Mental health in its broadest sense has come to mean the measure of a person's ability to adjust to life as he has to face it and to do so with a reasonable amount of satisfaction, success, efficiency, and happiness. . . . | 7 | 4 | 1 | 0 |
| 2. The conditioning forces of early years are the most significant forces in determining emotional patterns of behavior, which patterns tend to persist in adulthood, being the principal determinants of maladjustment or adjustment—*i.e.*, personality | 7 | 4 | 1 | 0 |
| 3. The child's home life is the most important element in his mental-health adjustment | 3 | 8 | 1 | 0 |
| 4. Almost all children suffer at some time from feelings of fear and inferiority | 8 | 2 | 2 | 0 |
| 5. Adults are responsible for many childhood fears by the examples they set and by the types of training they use with children | 6 | 3 | 3 | 0 |
| 6. Many neurotic conditions result from a feeling of insecurity | 5 | 6 | 1 | 0 |
| 7. Fear decreases confidence and efficiency to the point where children with exaggerated fears may become so unresponsive that observers may question their intellectual ability | 7 | 4 | 0 | 1 |
| 8. Sometimes the fearful child tends to compensate by developing an egocentric, aggressive, overbearing attitude. . . . | 8 | 4 | 0 | 0 |
| 9. Fear of ridicule and the hostility of others may lead to all sorts of reactions, as rationalizations, excuses, lying, running away, etc. | 9 | 3 | 0 | 0 |
| 10. It is risky to use fear as a means of frightening the child into desirable behavior | 7 | 4 | 1 | 0 |
| 11. A neurotic child should not be censured for his | | | | |

| *Final list of principles* | *Number of judges rating the principle* 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| failures, but should be allowed to be successful and to develop courage | 8 | 3 | 1 | 0 |
| 12. The adult's reaction to the child's natural curiosity about sex may result in having the child carry ever after a sense of guilt that attaches to anything that has to do with sex | 9 | 1 | 2 | 0 |
| 13. Children who do not participate freely in play and games and who are fearful of injury are subjects of potential mental ill health | 6 | 5 | 0 | 1 |
| 14. Independent, aggressive, experimental behavior is natural to child life. It is much wiser for the parent and teacher to direct this behavior into productive channels than to suppress or punish the child | 12 | 0 | 0 | 0 |
| 15. Children constantly experiencing irritation, frustration, and defeat in relationships with parent, teacher, school organization, or social institutions may develop negativistic attitudes in defense | 8 | 2 | 2 | 0 |
| 16. Honesty and deceptive behavior are specific rather than general traits. A child may be honest in one situation and dishonest in another | 8 | 3 | 0 | 1 |
| 17. It is unwise to meet the unhappy, defiant child with rigid discipline. It is better to help him to develop self-confidence and to secure satisfactions from school | 9 | 3 | 0 | 0 |
| 18. Squelching the show-off is likely to accentuate the behavior. It is better to ignore it, and to drop a word of praise whenever possible | 6 | 5 | 1 | 0 |
| 19. Truancy is best treated not by punishment, but by showing friendship toward the child and by making school attractive for him | 6 | 5 | 1 | 0 |
| 20. Except in rare instances, the type of discipline which humiliates the child or decreases his self-respect, pride, or personal integrity is injurious to personality, and various types of objectionable behavior may result | 7 | 4 | 1 | 0 |
| 21. Adults must be careful not to have the child feel that his acts have caused a loss of confidence in him | 6 | 4 | 2 | 0 |
| 22. The child's recognition of the natural disadvantages of misbehavior is ultimately more helpful to him than obedience enforced by fear | 9 | 2 | 1 | 0 |
| 23. By indulging the withdrawal type of behavior, the teacher increases the underlying difficulties of adjustment, and the undesirable expressions of social behavior are further entrenched | 6 | 4 | 2 | 0 |
| 24. A timid child is apt to substitute excessive reading and daydreaming for aggressive activity | 6 | 3 | 3 | 0 |
| 25. The child inferior intellectually may develop neurotic or delinquent symptoms because of inability to meet pressure placed on him by home and school to achieve scholastically | 6 | 5 | 0 | 1 |

| *Final list of principles* | *Number of judges rating the principle* 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| 26. One of the most potent forces for creating feelings of inferiority is ridicule. The teacher should never permit a class to ridicule one of its members | 9 | 1 | 1 | 1 |
| 27. A child with conflicts of inferiority may develop traits opposite to his original characteristics—*e.g.*, he may become domineering, a bully, a show-off, etc. | 7 | 3 | 2 | 0 |
| 28. The school should teach the child to realize his limitations, to compensate wisely, and to allow others to be superior without himself feeling inferior | 9 | 3 | 0 | 0 |
| 29. In physical education or on the playground, the child afraid to try many things may be assigned at first to less frightening things, such as keeping score or playing in a small group with the teacher, so that he will experience success | 6 | 5 | 1 | 0 |
| 30. In overcoming feelings of inferiority and developing a wholesome personality, it is highly important that the child be successful in his undertakings, and that he develop prestige in some field | 10 | 2 | 0 | 0 |
| 31. Children of low intelligence should have a different kind of education, not just less of the same kind that others get | 10 | 2 | 0 | 0 |
| 32. The curriculum should be so selected, organized, and administered that the children will be given worthwhile activities of interest to them, adapted to their abilities, and fitted to their needs | 10 | 1 | 1 | 0 |
| 33. The matters with which pupils deal in their group life and government should be important ones for them. | 7 | 3 | 1 | 1 |
| 34. Adaptation to school is difficult for beginners, especially if they have had few playmates of their own age and have had to adapt to few individuals | 6 | 4 | 2 | 0 |
| 35. A child who is given responsibility at an early age, and who is taught to face problems squarely, meets school difficulties with less emotion than a child who has had the protection of his parents in everything | 8 | 3 | 1 | 0 |
| 36. We should not become angry with behavior disorders in children any more than we should become angry with the child for having fever or tonsilitis, for behind behavior disorders lie causes in home or social environment | 10 | 2 | 0 | 0 |
| 37. Social responsibility and desirable attitudes can be developed through recreational interests such as club work, classroom activities, and social programs | 5 | 6 | 1 | 0 |
| 38. The child handicapped physically does not need sympathy so much as help in learning to compensate in a healthy way | 10 | 2 | 0 | 0 |
| 39. Each success in meeting life gives the child additional confidence, while chronic defeat robs him of the feeling of self-reliance | 11 | 0 | 1 | 0 |

| Final list of principles | Number of judges rating the principle | | | |
|---|---|---|---|---|
| | 1 | 2 | 3 | 4 |
| 40. In child development, success is more likely to follow treatment of the underlying pathology of the behavior disorder than treatment of the symptoms of the behavior maladjustment | 8 | 3 | 0 | 1 |
| 41. Instead of facing realities, some individuals evade them in many ways, such as temper tantrums, sulkiness, neurotic pains, forgetfulness, sleep, hysteria, rationalization, and criticism of others | 7 | 2 | 3 | 0 |
| 42. People with feelings of inferiority are often easily embarrassed and highly sensitive | 5 | 4 | 3 | 0 |

In order to discover how well teachers understand the most important principles of mental hygiene, a test was formulated exemplifying these principles. This was done by giving a brief description of a child behavior case and suggesting three plausible answers as to the probable cause of the disorder or the best way to treat it as a general rule. Samples of some of the test items follow.

*Principle No. 6.*—Evelyn, fifteen years old, is very nervous, worries much, and is generally afraid to try anything new. She cries a great deal and looks upon the future with dread. Which of the following do you consider to be the most important in causing her condition?

a. Her school work is poor. She is failing in two subjects.
b. She goes to many shows and is often out late at night. She is very irregular in her eating habits and buys much ice cream and candy.
c. Her father and mother quarrel almost constantly and threaten to separate.

*Principle No. 10.*—When Mary Jane was in the second grade, she was very troublesome and unruly. Following the principle of segregating the troublesome child, the teacher took her to a dimly lighted room in the basement used for storage of janitor supplies. Here she was instructed to sit until she felt that she could return to the classroom and behave. She could hear the rats playing and squeaking in the walls, as well as ot r weird noises. Soon, thoroughly frightened, she ran back upstairs cry ig.

a. The teacher discovered a good way of getting Mary Jane to behave.
b. The fear aroused did more harm than good.
c. The teacher used the child's fear to help her realize the value of good behavior.

*Principle No. 16.*—Don was caught cheating in a bookkeeping examination. In a discussion concerning honesty, a group of teachers expressed the following opinions. Which do you consider to be correct?

a. "I would not trust Don anywhere, since a boy who will cheat will steal."
b. "Just because he cheats is no indication he will steal. He may be dishonest in an exam. and still be trustworthy elsewhere."

c. "Some people are naturally dishonest, and never get over it. I'd want to find out whether or not Don is of that type."

*Principle No. 20.*—Henry sprinkled a foul-smelling drug around the schoolroom. The odor was so offensive that it made some of the pupils ill and almost broke up the school session. When she discovered who did it, the teacher forced him to apologize to the school and to stand before the class each morning for a week, taking a smell from a vial of the foul-smelling drug which she kept in her possession.

a. The form of punishment is good.
b. The form of punishment is not severe enough for the offense.
c. A humiliating type of punishment such as this is seldom good.

*Principle No. 23.*—Sylvia, a shy, timid girl thirteen years old, of normal intelligence, does not enter actively into games on the playground, or into class work. The principal says, "Let her alone." What do you think will be the probable effect of such a policy?

a. Probably she will outgrow her timidity in time.
b. Probably she will continue to be timid, or she may become even more timid.
c. Probably she will develop into an antagonistic type of individual.

*Principle No. 25.*—Fred, in the seventh grade, is a constant trouble-maker in school, has played truant several times, and has been brought before the police judge for rowdy actions around town. A study of the case showed the following facts. Which seems to be the most probable cause for his actions?

a. He gets up at 5:00 A.M. to cover a paper route. In this manner he earns money for anything extra he may desire. His parents buy his clothes.
b. His intellectual ability is low and he has had to repeat two grades. The teacher and his folks at home have to "keep after him" to make him do his school work. When he works he is barely able to pass.
c. His father is a laborer of foreign birth. His home is clean, but does not have any luxuries, such as a radio, magazines, and books.

In this manner, a test was compiled exemplifying 57 of the principles rated highest by the judges. In order to validate this test, it was submitted to sixteen judges selected as before. Of this group, eight were connected with child-guidance work, five were teachers of psychology and mental hygiene in institutions of higher learning, and three were in some form of psychiatric work. The following directions were given to each individual checking the test:

"Each question considers the case of one individual. Consider each answer in the light of the mental health of the child concerned *only*. Do not take into consideration what might be best for the group as a whole."

"Each question is an attempt to illustrate a general principle. Therefore, check the answer you believe to be true *as a general rule*. It is freely admitted that there might be certain conditions when other answers might be true also."

"If you think none of the answers are correct, star [*] the question and write the correct answer on the back of the sheet, being sure to give your answer the same number as the question starred."

If 87 per cent or more of the judges agreed upon a response, the item was retained. Thus a revised test of 42 items was compiled to submit to teachers. Of this number, the judges agreed 100 per cent on 21 of the items, 93.75 per cent on 15 items, and 87.5 per cent on six items.

In seeking teachers to take the test, a cross section of the profession was selected, including teachers in rural schools, grade schools, high schools, supervisors of teachers in training in high schools and teachers colleges, teacher-training students in high schools, and student teachers in teachers colleges. Rural teachers in two counties and teachers in more than one hundred grade schools, high schools, and teachers colleges coöperated. A total of more than 1,600 individuals took the tests. Each individual filled a personal data sheet, indicating the type of school in which he was teaching; the number of weeks of his college training and the type of institution in which the training was taken, whether university, denominational school, or teachers college; his years of experience; and the amount of his training (if any) in mental hygiene.

Since the schools in which teachers were teaching varied in size, an arbitrary grouping was made as a basis for comparison. Teachers in schools with less than twenty-five teachers were classed as "small grades" or "small high school," while teachers in schools with twenty-five or more teachers were classed as "large grades" and "large high school." No large city systems were included. High-school students taking the teacher-training course were classed as "high-school students," and student teachers in teachers colleges were classed as "student teachers." Supervisors of student teachers and of the high-school teacher-training groups were classed as "supervisors." The scores of teachers in each group were determined, and the means of the groups compared.

A more significant treatment in so far as this study is concerned was a tabulation of the percentage of error on each test item, indicating which of the principles were least known by the teachers. No effort was made to compare test results

with intelligence ratings. It was possible, however, to correlate the test scores with the scholarship ratings of a group of student teachers.

It is interesting to note the principles in relation to which the most errors occurred, since they show in what phases of mental hygiene the teachers are weak. While it is not possible to make a sharp classification of the principles under separate headings, since in a subject such as mental hygiene there is much overlapping, nevertheless it is significant that the items relating in some way to fear and those relating to the relationship of adults to children showed the most errors. These topics, therefore, should receive emphasis all through a course in mental hygiene. Again, the teachers did not show a comprehensive knowledge of the part the school plays in the mental health of the child. Surely this should be impressed upon individuals, who hold such an important place in child training.

Some examples of principles upon which a high percentage of error occurred follow:

| | *Percentage of error* |
|---|---|
| By indulging the withdrawal type of behavior, the teacher increases the underlying difficulties of adjustment, and the underlying expressions of social behavior are further entrenched | 52.3 |
| A child with conflicts of inferiority may develop traits opposite to his original characteristics—*e.g.*, he may become domineering, a bully, a show-off etc. | 41.6 |
| A timid child is apt to substitute excessive reading and daydreaming for aggressive activity | 40.3 |
| The child's home life is the most important element in his mental-health adjustment | 37.6 |
| Each success in life gives the child added confidence, while chronic defeat robs him of the feeling of self-reliance | 35.5 |
| Children of low intelligence should have a different kind of education, not just less of the same kind that others get | 31.6 |
| Instead of facing realities, some individuals evade them in several ways, such as temper tantrums, sulkiness, neurotic pains, forgetfulness, sleep, hysteria, rationalization, and criticism of others | 30.4 |
| Honesty and deceptive behavior are specific rather than general traits. A child may be honest in one situation and dishonest in another | 30.0 |
| The curriculum should be so selected, organized, and administered that the children will be given worth-while activities of interest to them, adapted to their abilities, and fitted to their needs | 30.0 |

| | *Percentage of error* |
|---|---|
| The child inferior intellectually may develop neurotic or delinquent symptoms because of inability to meet pressure placed on him by home and school to achieve scholastically.... | 29.0 |
| Many neurotic conditions result from a feeling of insecurity. | 29.0 |
| People with feelings of inferiority are often easily embarrassed and highly sensitive..... | 25.0 |
| The adult's reaction to the child's natural curiosity about sex may result in having the child carry ever after a sense of guilt that attaches to anything that has to do with sex..... | 25.0 |

The percentage of error on the various items ranged from 52 per cent to 3 per cent. The average error for 1,024 teachers actually teaching in public schools was 19 per cent. As might be expected, the supervisors scored highest, with an average error of 10 per cent. The high-school teacher training students ranked lowest, with an average error of 25 per cent. Student teachers in teachers colleges, with an average error of 16.5 per cent, ranked higher than the average of teachers actually teaching in the public schools.

It was possible to secure the scholastic ratings of student teachers, which were correlated with their test scores. The resulting coefficient was quite high, being .90.

Individuals taking the test were invited to comment on the items. In many instances their comments showed a good understanding of the principles involved. More often than not, however, the comments indicated disagreement with modern mental hygiene. To judge from the items that received most comments, the following seem to be the attitudes of the teachers who commented:

1. They are very cautious about giving sex instruction.
2. They do not wish a child to be invariably successful. They are afraid that children will not learn the meaning of failure.
3. They lay the blame at the door of the home for the maladjustment in school of the beginning child. They do not seem to recognize that beginning school is a time of stress for the child.
4. They do not often recognize that some traits, such as apparent egotism, are often merely compensations for a feeling of inferiority.

5. They do not seem to recognize that honesty and deceptive behavior are specific rather than general traits.

It is interesting to compare the means of the various groups. In order of rank from highest to lowest, the order is as follows: supervisors, large high school, small high school, large grades, student-teachers, small grades, rural, high-school teacher-training students. The mean score of 1,024 teachers actually in the public schools was 34.45 on a test of 42 items. The mean of the supervisors was 37.41, and that of the high-school training group was 31.2. Experienced teachers showed considerable superiority over inexperienced teachers. Teachers who had had courses in mental hygiene showed superiority over those who had never studied this subject, although the difference was not extreme, the chances being 77 in 100 that the difference is reliable. It might be stated, however, that many teachers who reported courses in mental hygiene took them some time ago when more emphasis was placed on the abnormal than on training positively for mental health in childhood. Teachers who had had more than four years of college training were much superior to those who had had one and a half or less years of training. Teachers trained in both teachers colleges and universities ranked higher than those trained in other institutions, while those trained in teachers college alone ranked lowest. The latter group, however, included more than 90 per cent of the rural teachers, which tended to pull the average down, since the rural teachers ranked low as a group. When the rural teachers were removed from the teachers-college group, the order was changed, and the group trained in denominational schools ranked lowest. There seems to be no apparent explanation for this. These comparisons merely state the situation, but do not give any objective measures regarding causes for differences..

## CONCLUSIONS

1. Enough teachers show a lack of knowledge in mental hygiene to justify the conclusion that some method should be used to require those who lack information to take some up-to-date training in the subject.

2. On nine statements only were less than 10 per cent of the teachers in error. On twelve of the statements more than 25 per cent of the teachers were in error.

3. Experienced teachers as a group have better knowledge of mental hygiene than inexperienced teachers.

4. Teachers with the most preparation as a group have a better knowledge of mental hygiene than teachers with little preparation.

5. Teachers who are parents or who have had small children in their homes show no superiority over those who have not had this experience.

6. The topics of fear, sex, responsibility of adults in the personality development of children, and the importance of schools in the development of personality in children need to be stressed in courses in mental hygiene.

### RECOMMENDATIONS

Since teachers erred on approximately one out of five of the fundamental principles of mental hygiene, it seems evident that they need training in the field. The part that they play in the life of the child is so important that their knowledge of the fundamental principles, at least, should be thorough. It is suggested:

1. That an up-to-date course in mental hygiene as it applies to childhood be required of every prospective teacher.

2. That administrators use mental hygiene as a topic for a series of teachers' meetings, thus in a measure bridging the gap for teachers who have not had training in this line, and bringing abreast of the times the knowledge of those whose training is somewhat out of date.

3. That educational periodicals, such as teacher-association journals, publish a suggested list of readings in mental hygiene.

4. That public libraries be requested to secure a few books on mental hygiene as it relates both to adults and to children.

# THE RELATION OF MENTAL GROWTH TO PERSONALITY AND ADJUSTMENT *

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THE term "mental growth" is loosely used in a number of different senses. As opposed to the term "physical growth," mental growth may properly be held to include all changes in type of response to external stimuli that presumably result from growth changes in the central nervous system. From the standpoint of the observer, mental growth is signalized by measurable changes in behavior, just as physical growth is signalized by measurable changes in structure. Among many persons, however, there is a growing tendency to restrict the use of the term "mental growth" to changes in the ability to think in abstract terms and to gains in the ability to acquire information and skills of an academic nature, while the age changes in attitudes, interests, desires, and feelings, although equally a part of the individual's mental make-up, are, by more or less popular consent, set off as belonging to the field of "personality."

The distinction is obviously an artificial one, even though an attempt at objectivity has sometimes been made by classing as "mental" those tasks not primarily dependent upon muscular effort that are presumed to show what the subject *can* do if properly motivated. "Personality," on the other hand, is assumed to be not so much a matter of ability as of habitual conduct. Yet it must be evident that such a distinction is based upon a number of unproven assumptions, and is not altogether untainted by the doctrine of "free will."

Only slightly more objective is the division of behavior into such classes as intellectual, social, emotional, and motor activities. Strictly speaking, almost every action partakes of each of these classes in certain of its aspects at least, even though one class may seem to predominate over the other to

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an extent that may warrant us in ignoring its other aspects for purposes of practical convenience.

We should not, however, lose sight of the following highly significant facts: first, that any categorical division of behavior, such as that just described, is merely an artifact, justifiable only by reason of our need for reducing the data with which we have to work to a form of order that is amenable to treatment by the rather primitive methods thus far at our command; and second, that while such a classification may hold, within rough limits, for the average or most typical performance of groups, in individual cases it may completely break down. Thus, while the well-known task of repeating a series of digits after a single hearing may be, for the majority of persons, almost wholly a test of what is commonly known as "intelligence," for an occasional person whom previous experience has chanced to sensitize to performances of this kind, the task may induce a response that is determined almost wholly by emotional factors. For the stutterer, it may be predominantly a task of motor coördination; for the extremely shy child, it may become primarily a test of social adjustment. To assume that the psychological character of a task is determined, once and for all, by the name that has been assigned to it, or that the kind of demand it makes upon the individual is inherent in the task itself, rather than in the subjects who respond to it, is to commit a stimulus error of a particularly vicious kind.

I have been asked to discuss to-day the topic of mental growth in its relation to personality and adjustment. In as much as the term "mental growth," in its broader sense, must include "personality growth," the relationship would necessarily be that of a whole to one of its more specific aspects. Although this might be an illuminating and effective way of approaching the topic, I assume that those who arranged the program had in mind a somewhat more limited definition of the term. I shall, therefore, confine my discussion to those aspects of mental growth that are popularly linked together under the heading of "general intelligence"—that is, the ability to think in abstract terms, to perform tasks of increasingly greater complexity, to make effective use of symbols and other short cuts for securing the desired results.

This brings us directly to the question of measurement. For however fashionable it may be just now to decry the use of measurement in this field, and however just may be the criticisms that have been aimed at certain published investigations, the fact remains that no science can progress far on a purely descriptive level. A given measurement may be so crude as to be misleading in many individual instances in which it is used; nevertheless, the concept of measurement is a step in the right direction. We must always maintain a critical attitude toward the imperfections in our work, but the consciousness of those imperfections should not lead us to give up in despair.

There are current, at present, two extreme points of view with reference to this problem, both of which tend to hamper further progress. On the one hand, we have the enthusiasts, who, dazzled by some high-sounding name that has been attached to a measuring device, apply this device in a blind and wholesale fashion to all comers and interpret their results with little regard to their scientific validity. Here we have a curious mixture of deliberate fakers and the well-meaning, but ignorant, among the group who classify themselves as "clinical psychologists" and "vocational-guidance experts." The "psychological profile," based upon a long list of tests with names that are as specific as their significance is vague, is a favorite device of these persons. At the other extreme we have a group who, perhaps as a natural revolt against such unthinking acceptance of uncertified names, would throw aside all attempts at measurement and revert to the old descriptive method of the case history. This is equally unfortunate. Indeed, as actually practiced, the case method frequently parallels the procedure of the uncritical user of tests in an amazingly precise way. We may substitute for the series of unverified tests the series of unverified statements elicited in the course of one or more interviews; for the unverified assumptions implicit in the names applied to the tests, we may substitute the equally unverified interpretations of the case-worker. If the final picture thus obtained appears to be more internally consistent and better integrated than the so-called "psychological profile," we can by no means be certain that this is due to better understanding of the factors involved.

The picture may be no more truthful, but since all the errors emanate from the same source, the results are likely to appear more coherent, though they may be equally mistaken.

With all due appreciation of the hazards involved, I, therefore, turn back to our feeble attempts at measurement and classification as offering the most hopeful approach to the study of personality and adjustment. If, as I think the majority of us believe, intelligent behavior is characterized by an increasingly more effective use of abstraction and symbolization, by means of which we are enabled to group similar facts into broader classes and thus deal with large units instead of small ones, then it seems apparent that an intelligent attack upon the study of personality and adjustment must, in the final analysis, involve more systematic organization and evaluation of the data with which we have to deal.

As a result of the continued and concerted efforts that have been made during the past quarter of a century, we have succeeded in devising a series of methods for the study of intellectual growth by the use of which our understanding of the nature and process of intellectual development in man has been at once greatly extended and enormously clarified. It is true that there is still much to be learned. It is also true that, as a device for the practical guidance of individuals, there can be little doubt that the mental test, as such, has been greatly oversold.

Perhaps one of the most serious errors in this respect has arisen from the unfortunately common practice of using the word "intelligence" as if it were synonymous with the results of some particular measuring device. The implication for the vast majority of people is that all tests that are labeled "intelligence tests" are essentially measures of the same thing, although it is admitted that some tests may be more accurate than others. Now the actual fact is that among the vast array of so-called "intelligence tests," which, to the uninitiated at least, *should* measure the same thing, it is extremely hard to find any two that, when applied to a group of children of homogeneous age and of normal variability, will yield intercorrelations as high as .87. That is to say, the improvement in accuracy of predicting a score on one of these tests on the basis of the score made on the other test is commonly less

than 50 per cent better than that which would be had by estimating that all cases would score at the mean of the group. In part, the lack of accuracy in prediction is due to the experimental errors of both tests. But it can also be shown that, in spite of their similar labels, the functions measured by the tests are not wholly the same.

It is not my purpose to-day to go into the many controversial issues centering around the problem of the nature of mental organization. Whether we look upon intelligence as a unitary trait, synonymous, at least for practical purposes, with Spearman's *g*, or as a multiple group of characters, as Thorndike defines it, there can be no reasonable doubt that the crude scores obtained on these tests and their simple derivatives, such as mental age and intelligence quotient, vary in meaning according to the particular tests from which they were derived. To apply the same name to such varied results is as unscientific in principle as it is misleading in practice. As an immediate reform movement, I should like to urge that all of us endeavor to break ourselves of the pernicious habit of speaking of a child's "intelligence" as if it were synonymous with the particular score that he happened to make on some unspecified test, and that we speak instead in terms of the particular score on the particular test that was given.

The point may seem a trivial one, but I believe it is basic if we are to clear up a number of misunderstandings on the part of the general public. I am inclined to believe that our own thinking will also be clarified by such a practice. We are too prone to forget that the significance of test results is dependent, not only upon the content of the test, but also upon the adequacy of the normative standards by which children are to be judged. These standards depend, not only upon the average performance of the original standardization group, but also upon the variability and kurtosis of a typical distribution of scores. Failure to make sufficient allowance for the latter factor is undoubtedly in part responsible for the widely varying results in the proportion of cases at the extremes of the distribution, when different tests are used in the study of special groups such as juvenile delinquents. Thus, Lane and Witty gave both the Otis group test and the Stanford-Binet individual test to 145 delinquent boys. The correlation be-

tween the two tests was +.84. The average intelligence quotient on the Stanford Binet was 79, on the Otis, 86. According to the Stanford examination, 28 per cent of the cases earned I.Q.'s below 70; while on the Otis tests, only 13 per cent were rated as low as this. If one were to adopt the formal statistical rule of classifying all children testing below 70 as feebleminded, then we should be obliged to place twice as many in that category if the Binet were adopted as the standard as would be the case if the Otis were relied upon. A still smaller percentage, fewer than 10 per cent, were rated below 70 on both tests.

These figures are in no way out of line with those that have been found by other investigators who have compared the results of different tests given to the same children. To assume that a mental age or an intelligent quotient has a uniform significance, regardless of the test from which it has been derived, is quite unwarranted. Yet the practice is very general, even among those who should know better.

Not only are we far too prone to generalize unduly upon the basis of names, but we are also inclined—particularly in our attempts to relate various characteristics of personality and conduct to one another—to lose sight of the extremely complicated network of factors with which we are dealing and to draw rather sweeping conclusions from a superficial examination of one or two of the strands. I made reference a moment ago to the problem of the relationship of intelligence, as measured by various tests, to juvenile delinquency. As most of you will recall, the earlier studies appeared to show that a tremendously high percentage, some investigations yielding figures as high as 75 per cent or 80 per cent of the inmates of juvenile reformatories, were feebleminded according to the standards then in vogue. More recent studies show considerably smaller figures, with from 12 per cent to 20 per cent of the inmates of a typical reformatory earning intelligence quotients below 70 on the Stanford-Binet, which is the test most commonly used.

The differences between the earlier and the more recent reports are in the main due to two factors: differences in the measuring devices upon which the classification is based, and an actual decrease in the number of the feebleminded in re-

formatory institutions due to the increasing social pressure which demands that these children shall be sent to institutions for the feebleminded rather than to reformatories. Even to-day, however, the percentage of children who earn very low scores on the standard tests of intelligence used, and whose social history and general conduct bear out the diagnosis of general mental backwardness, is somewhat higher among juvenile delinquents than in the population as a whole. Yet this relationship is not as simple as it sounds. For if we administer the same tests to other children in the neighborhood from which the delinquents typically come, we shall find that the difference in the test scores of the delinquents and the non-delinquents becomes very small and may even disappear. In other words, we have the factors of low intelligence, poverty, bad neighborhood conditions, and juvenile delinquency interwoven in such a way that it becomes extremely hazardous to say which is cause and which is effect.

It is not my purpose to enter upon a discussion of the relative potency of inborn tendencies and environmental influences in bringing about the diversity of abilities and conduct that strikes us so forcibly as we observe the growth and development of the human animal from childhood to maturity. In spite of my Presbyterian upbringing, I find myself quite unable to accept the doctrine of predestination as a universally valid explanatory principle, and I am equally skeptical about the claims of those alchemists who hope to be able to convert any kind of human material into the shining gold of genius by a proper admixture of ingredients in the environmental stewpot. The point that I wish to stress is that, as society is now organized, there is a fairly high correlation between the heredity background of the average child and the kind of environment in which he is likely to be reared. Since this is true, it is not surprising to find that poor heredity, poor environment, low standing on recognized tests of intelligence, and juvenile delinquency occur in combination with far more than chance frequency.

This fact has a social corollary that has, I think, received too little consideration. The social control of reproduction among the socially unfit has by most persons been thought of wholly as a eugenic device in the most literal sense of the

term. That the gain to be accomplished by such methods through improving the hereditary stock would be far slower than its advocates of twenty years ago supposed is now generally admitted, though there is little doubt that some improvement would be brought about in that way. But there is another side to the question. In as much as most children are reared by their own parents, is not the argument for the social control of reproduction even stronger from the environmental standpoint than from the standpoint of heredity? Modern geneticists tell us that in all probability it would require many generations of complete control in order to reduce by half the number of cases of hereditary mental deficiency in the general population. But it is possible in the course of a single generation to reduce the number of feebleminded *parents* almost, if not quite, to the zero point if we have the social courage to do so. Thus one factor in the network of circumstances contributing to those overt forms of social maladjustments that make for juvenile delinquency would be largely removed. Whatever other provisions may be included in the child's bill of rights, the right to be born of *and reared by* parents of reasonably normal intelligence should certainly stand high in the list.

If we now turn to the less conspicuous, but perhaps equally serious symptoms of maladjustment represented by such characteristics as seclusiveness, unhappiness, extreme daydreaming, oversensitiveness, and sulkiness, we find the relationship to intellectual development far less apparent. It has been the fashion among certain groups to look upon this group of problems as being almost wholly confined to the intellectually superior, but I have been unable to find any convincing evidence for this point of view. One of the major difficulties in studying this question lies in the paucity of dependable methods for diagnosing personal-social maladjustment. Such measures as are available suggest that the intellectually superior show, upon the whole, better adjustment in respect to personal-social traits than do the intellectually inferior. The difference is not great, however, and since most of the group studies have made use of one or another of the various paper-and-pencil tests, it is not impossible that the small superiority of the abler subjects is largely, if not wholly, a result of their

greater ability to select the socially acceptable replies. Even the most casual observation of human behavior will serve to convince any unprejudiced person that such traits as unhappiness, seclusiveness, unpopularity, suspiciousness, and the like are not confined to any single group, but occur in all social classes and at every level of ability. Whether or not they occur with equal frequency within these groups is something that we are unprepared to say from the data thus far available.

If, however, we look at the question from the standpoint of the relationship between environmental demands and the ability of the child to meet those demands, we find a somewhat different picture. The backward child in a brilliant family is a familiar picture to most clinicians. If the other children are older than he, his childhood is likely to be passed in a never-ending and hopeless struggle to live up to the standards that have been set for him. At home, at school, in the neighborhood, wherever he turns, he is continually faced with demands that he is truly unable to meet; he is constantly failing in spite of his best efforts. It takes an exceptionally sturdy personality to stand up under such conditions. If, on the other hand, he chances to be the oldest child, the situation may seem to be more favorable at first, but it does not long remain so. Soon he finds that he is being steadily outstripped by his younger brothers and sisters—an experience that is humiliating at best and that is frequently aggravated by the unthinking comments of his teachers and the jeers of his playmates.

We should note, too, that the child need not be actually backward for this condition to exist. He may even be above the average of the general population and yet be sufficiently below the average of the other members of his family to develop a serious feeling of inadequacy as a result of the comparison. As a matter of fact, one of the most extreme cases of this kind that I have ever known was that of a ten-year-old boy with an intelligence quotient of 140 who was unlucky enough to have a twin whose intelligence quotient was 180 and who was two grades ahead of him in school.

Maladjustment may also occur when an exceptionally bright child is reared under conditions that do not afford sufficient scope for his interests. Through sheer boredom, such chil-

dren may be driven to all sorts of devices for amusement, and it sometimes happens that the schemes they adopt lead them into serious difficulties.

Cases such as these suggest rather strongly that the relationship of mental growth to personality and adjustment is not a simple matter of direct cause and effect, but that it arises through the interaction between the developing abilities of the child and the external demands that he is expected to meet. Although one may be able to meet certain requirements and fail to do so for any one of a variety of reasons, yet we cannot escape the fact that the level of ability possessed by any person must always set limits to his performance. As society is now organized, it frequently happens that economic, social, or educational demands are truly beyond what the individual is able to meet, and when this is the case, difficulties are likely to arise.

If this point of view is accepted, it would seem that no matter whether our interest centers about the scientific problem of finding out the facts or about the more immediately practical question of how best to help the individual, more adequate methods of reducing our data to a form that is at least partially quantitative are greatly needed. No matter how good they may be, intelligence tests are not enough. It is equally essential that we develop more suitable methods for defining and measuring the environment within which personality and conduct are shaped. And the devices that have so far been developed for this purpose are few and feeble.

Particularly is this true in regard to the more subtle factors of family relationships. There are a number of concrete factors in the home and neighborhood—such as family income, ownership or non-ownership of a telephone or automobile, the number of books in the home library, or the educational level of the parents—that serve as rough indicators of the general cultural and economic features of the home environment. A number of composite measuring devices based upon rather simple and obvious factors such as these have been devised, and they have a certain amount of usefulness. Yet I doubt that they really strike at the roots of the problem. The fact that the parents of a certain child are

college graduates may matter very little in comparison with the lack of harmony in the home atmosphere. An income of $10,000 per year which is frittered away in the course of a never-ending struggle to keep up with the Joneses may actually provide fewer of the intellectual and cultural requirements of childhood than an income of a fourth of that amount more wisely expended. An expensive apartment, elaborately furnished, may include no space in which children can play. Most studies have shown that a greater percentage of delinquent than of non-delinquent children come from homes that have been broken by the divorce or separation of the parents, but we have no way of knowing whether the actual break in the family circle or the emotional tension and family disharmony that led up to the break is the primary factor involved. It is entirely possible that there are many other cases in which it would be better for the children if the home were broken. It is the psychological environment rather than the material goal that is of chief importance.

If it seems to you that I have said very little about the relationship of mental growth to personality and adjustment, my excuse must be that I feel that in the present state of our ignorance there is very little of a general nature that one is warranted in saying. I hope, however, that I have succeeded in pointing out the inadequacy and superficiality of many of the rather sweeping generalizations which have been drawn with regard to this relationship, and that in so doing, I have suggested some of the next steps which seem most likely to lead to advancement. Among these we may note specifically the following: The need for clarification of language, the substitution of exact statements based upon actual facts elicited and actual measuring devices used in place of vague, general statements in terms of so-called "traits" which are loosely defined and at best only very imperfectly measured. We must continue our attempts to refine our measuring instruments. If it should prove, as present indications seem to suggest is possible, that the trait as a category for describing conduct is specific to the situation under which the conduct is displayed, this means only that we should change our line of attack. Instead of attempting to develop instruments that will predict conduct regard-

less of conditions, we must devote more attention to developing ways for measuring the conditions under which conduct occurs. In doing this, we must not forget that the things that are most obvious are not always the most fundamental. The problems of mental growth, like those of other characteristics that go to make up the child's whole being, are so inextricably interwoven with the problems of measuring and defining the conditions under which this growth takes place as to render it extremely hazardous to draw any sweeping conclusions until more adequate methods have been devised for studying these conditions, in their intangible as well as their external aspects.

# PSYCHIATRIC RESOURCES FROM THE STANDPOINT OF SOCIAL AGENCIES*

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DOUBTLESS the outstanding contribution that social work has made to method in the field of human behavior is social case-work. Social case-work, to quote a generally accepted definition, "denotes specific processes through which an expert service is rendered to develop within the individual his fullest capacity for self-maintenance and at the same time to assist him in establishing for himself an environment which will be as favorable as may be to his powers and limitations."

The concept of social case-work has been developed, not from abstract thought, but from the trial-and-error efforts, over more than half a century, of people who were faced with the task of finding ways to help other people out of trouble. Social workers have come to know people in terms of life as it is lived; to them, therefore, the individual has never been an isolated unit, but truly a social animal. So, although the basic method of social work centers on the individual, the experienced social worker seeks to know and to work with that individual in his social setting, in full practical recognition of the fact that the cultural forces operating upon the individual combine with the developmental forces within the organism to make him what he is.

Of all the social institutions that, so to speak, grow into the individual, social workers have, again in a practical way, seen the family as the most basic—the primary group in which "as a result of intimate association psychologically, there is a certain fusion of individuals in a common whole, so that one's self, for many purposes at least, is the common life and purpose of the group," and in which consequently the social nature and ideals of the individual are molded. There is, therefore, no inconsistency in regarding both the individual

* Read at a meeting of the Division of Psychiatry of the Department of Hospitals, City of New York, December 16, 1936.

and the family as the unit of treatment, as the social worker does.

Because social-case-work practice reaches into family and home life, into marital relationships and parent-child relationships, social agencies with staffs professionally well equipped may be considered important links in a community mental-health program. Private family agencies more and more are devoting themselves to the service of families and individuals, whether or not their personal and social problems are associated with economic need. These social agencies are concerned with the development of mental-health influences within the family circle and with prevention and early treatment before social maladjustment reaches the point where psychiatric treatment is indicated. By the same token, social agencies discover in families under their care problems that are beyond the ability of the social worker to cope with—that call for definite psychiatric attention, certainly as to diagnosis and frequently as to treatment. Then the social worker looks about her for psychiatric resources, and all too often is unable to find the resource needed. The consequence frequently is the necessity of tolerating a psychiatric problem that is nothing short of devastating to family life.

Eyewitnesses of the needless tragedies that result from serious lacks in the psychiatric program, social workers are aroused to the importance of action. We recognize, however, that these lacks reflect public indifference and prejudice, and, therefore, we see our rôle as one not of standing off and criticizing, but rather of lending all possible assistance to a program of community education and planning as essential to the proper support of psychiatric services.

In our own experience, one of the first obstacles encountered is the commitment laws which establish a *legal* definition of insanity and condition the procedures under which the mentally ill may be placed under medical care. We question the present laws and administrative procedures because of the antediluvian concepts behind them. We realize that changes in the laws can probably be instituted only as changes can be brought about in public opinion. Here we face as a practical problem the need for persistent public education that will give psychiatry its proper authority to define ***medically*** the point

at which the mentally ill must be placed under institutional treatment.

We question the legal concept of insanity, which often imposes a long period of suffering on both the patient and his family when a voluntary admission is impossible of accomplishment and hospital treatment must wait until sufficient legal basis for commitment can be found.

In 1933, Mrs. Gertner[1] first told the case-worker of her husband's alcoholism, with its attendant difficulties in social adjustment. He made excessive sexual demands, was physically and verbally abusive, and threatened to violate the eleven-year-old daughter. In August, 1934, Mrs. Gertner called for the police, and Mr. Gertner was jailed for a few days. On his release the difficulties were repeated in strong focus on the daughter. In December, 1934, the social agency, with his consent, made an appointment for him at a mental-hygiene clinic, which he did not keep. The case-worker then discussed with Mrs. Gertner the advisability of calling an ambulance and asking for observation of her husband. After that she called a policeman on three different occasions. Twice the policeman scolded and lectured Mr. Gertner, and the third time again took him to jail. He was immediately placed on probation and again began to drink the day after his release.

On the occasion of a particularly bad outbreak in October, 1935, the young daughter, sobbing and crying that if her father were not removed, she would run away, again called the police; but while she was out of the house Mr. Gertner escaped, to return the next day. Subsequently Mrs. Gertner became increasingly upset and threatened to kill herself and the children. The agency conferred with Mr. Gertner's probation officer, to request thorough mental and physical examinations. Mr. Gertner was brought into court on Mrs. Gertner's warrant at a time when the probation officer had not expected it. The judge was, therefore, uninformed about the case, no examinations were ordered, and Mr. Gertner was sentenced to ten days in jail.

In February, 1936, Mrs. Gertner on her own initiative took Mr. Gertner to magistrates court on a charge of disorderly conduct. The social worker appeared, described the symp-

[1] Not the real name.

tomatic behavior, and asked for commitment for observation. This the judge at first refused without specific evidence from Mrs. Gertner of psychosis, but after further observation of her distress, he revoked his decision.

After a period of observation, Mr. Gertner was released from the hospital. He was found to be very much depressed, in a deteriorated state, with a hopeless prognosis, but not committable at this point. The court released him, not putting him on probation, but ordering him to take a pledge to control his drinking. During all of this the social agency had the utmost coöperation from the medical authorities of the hospital, but the difficulty lay in the need for *legal* rather than *social* justification.

From February, 1936, until May, 1936, there was no great disturbance. In May Mr. Gertner left his work-relief job for one in private industry, and on the first day dropped a tool, inflicting upon himself a serious leg injury. He was on the ward of a private hospital for a month, and when released to his home, immediately began to drink and show exaggerated evidence of social unadjustment. He threatened Mrs. Gertner with a knife, made sexual demands in front of the children, and behaved so that the daughter left home for a few days. On one of these occasions, he beat Mrs. Gertner so severely that she fainted on the street as she was coming to the social agency for help in this most recent crisis. Though the daughter had called a policeman at once, no action was taken. It was not until the social worker, who immediately went down to the house, herself called a second officer that Mr. Gertner's commitment to a state hospital was finally effected.

This case is significant because of the three-year period before commitment could be obtained, the suffering imposed on all members of the family, the actual physical dangers involved, the particularly bad psychological effects on the daughter, and the crisis that had to be reached before the family could legally be relieved of its burden. Such instances, in which it is impossible to secure commitment until dangerous and socially expensive antisocial behavior is manifested, are all too familiar to the social worker.

We question also the responsibility that, as a consequence of the present law and practice, is placed on the police or on members of the family to make what is tantamount to a diag-

nosis in a situation that calls for medical opinion. A client whose husband was at work went suddenly into a psychotic episode in the presence of her three children, four and six and seven years old. Neighbors found her screaming and yelling, smashing up the furniture. They called the police, who, making their own diagnosis of the situation, instead of sending for an ambulance, sent for her mother, who lived at quite a distance. The woman and her children were removed to her parents' home, where she continued to exhibit violently disturbed behavior. Her children, her parents, and her siblings were exposed to this for forty-eight hours, when the social agency to which the patient was known was notified by the family and arranged at once for her admission to the appropriate hospital.

Clinical facilities for psychiatric examination and treatment are shockingly inadequate. While it is impossible to measure their inadequacy because so many cases in the community cannot be diagnosed under present conditions, studies made by the New York City Committee on Mental Hygiene have furnished facts as to the quantitative lacks. In our direct experience, provisions in public and private hospitals for either diagnostic or treatment services are quite insufficient to meet the demands that are made upon them. The need is not only for expansion of psychiatric-hospital facilities for reception, treatment of short-duration cases, and observation leading to state-hospital care if indicated, but also for the establishment of psychiatric clinics in both public and private hospitals.

Furthermore, there is urgent need for a closer coördination between psychiatric and medical clinics, and between psychiatric clinics and in-patient facilities. If the referring of a patient from medical to psychiatric clinic service, or from the latter to the observation ward, were made a simpler matter, it would save the patient, his family, and society some costly experiences.

Frequent changing of the psychiatrist on the case is a serious obstacle to adequate diagnoses and successful treatment in the clinic. In addition, such changes hinder the realization of thoughtful case-work plans made by the social agency. We fully realize the economic problems involved in increasing clinical facilities and stabilizing clinic staffs. As social agen-

cies, we perhaps need to face our responsibility for securing more adequate data about the social costs to the community that are entailed by the present lack of adequate financial support for proper diagnostic and treatment facilities. Even now, while we lack quantitative data, we are fully aware of those costs in such terms as the delinquency of the potential patient; the impaired health, physical and mental, of members of his family exposed to his erratic, unpredictable behavior; homes deserted by his children or broken by dissension because they can no longer endure the psychological pressure of his presence; economic strain involved in caring at home for an incapacitated person whose needs demand extra expenditures or whose care prevents others from earning. These are but a few of many consequences.

There is another fundamental quantitative lack in our present provisions, and that is a lack of trained social-work personnel in clinical and hospital organizations. This particular lack means that in many cases the psychiatrist may be handicapped in securing the information essential to competent interviewing, diagnosis, and recommendations, and that some of the best possibilities for treatment or social adjustment are sacrificed. Even when satisfactory diagnoses are made, the absence of social-service resources often results in the waste of expert advice when social service is indicated as the medium through which that advice can be utilized.

In another area this lack of social service entails a serious waste of such facilities as our hospital system can provide. The quantitative inadequacy of hospital social-service staffs results in various follow-up failures. The patient who has been helped by his hospitalization is left altogether too much to his own devices at the critical point of parole, so that the improvement effected by the hospital is undermined. Patients are frequently paroled to return to conditions within the family or community which are unfavorable to continued improvement.

A family in which a grown son had been hospitalized for dementia praecox came to the social agency for financial assistance in March, 1936. A report from the hospital during that month indicated a guarded prognosis for the young man's recovery. In May the social agency again asked for a report, which stated that the patient's condition showed little change.

At this time the agency in a letter requested a conference with the hospital social worker. That nothing came of this request and that in September the son was paroled without any notification to the agency, or any request for information as to home conditions, is no doubt a reflection of the fact that this hospital was inadequately equipped with social workers. The home environment was anything but favorable to a returning patient. The mother and older sister were highly disturbed. Ostensibly they were worried over the financial situation, which was distressing, but beneath that were evidences of more serious difficulty. The mother was overanxious and in conflict over the fact that mental illness had appeared in the family; the sister was obviously slipping into a depression and openly expressing her fear that she was getting just like her brother. The son immediately reacted to the overcharged atmosphere by leaving home to visit a relative, who, however, was unable to keep him longer than a few weeks. There is still grave question about his adjustment, as he is fearful of crowds and the subway, thereby missing follow-up appointments at the parole clinic and keeping the family in a constant state of worry lest he be too ill to remain at home.

Closely connected with this problem of parole is another. With an insufficient number of hospital and clinic social-service workers, it is impossible to utilize the resources of the community which might be employed in behalf both of the patient and of his family. If social agencies could be called into service at the time of commitment, or soon after, they might frequently effect changes in the patient's home or community situation, and also keep the hospital informed of conditions, so that parole might be more timely and constructive for the patient and his relatives. Such coöperative service between the two kinds of agency is now a practical impossibility, yet it is utterly indispensable as a means of working out the patient's adjustment in the outside world. It would be valuable to estimate how many recommitments it would eliminate at a tremendous saving both of money and of psychological suffering.

At this point, where we are properly occupied with gross needs in an area that has been badly neglected, it seems important to concentrate on the need of more, and more adequate, diagnostic services and better institutional care.

Until these basic services are more generally available, many of the practical problems of treatment cannot even be faced. This, however, is not to overlook the necessity for a more constructive attack on the vital need for psychiatric-treatment services, and the importance of making treatment available before the patient has reached the stage of total incapacity. Nor can we responsibly omit to mention the crying need for more services to diagnose and treat problems of neurotic and delinquent behavior and milder conditions than those of psychosis. These are rife in the community and prominent among the problems of social agencies. One of the most economical and effective devices for reaching them would be through the expansion of psychiatric *consultation* services which could be used by qualified social-work agencies confronted with the problem of handling the social aspects of these difficulties. At present the social agencies are carrying a totally inappropriate responsibility in so far as they are obliged to make case-work plans for persons the nature and significance of whose mental disturbances cannot be determined because consultation service is unavailable.

In stressing these needs for supplying the lacks in psychiatric resources of which we as social workers are so acutely conscious, we would not overlook the corresponding responsibility of social agencies to see that their staffs have the professional equipment which will enable them to make intelligent use of such resources and to work helpfully with the medical and social-service staffs of psychiatric hospitals and clinics.

Starting with the institutional treatment of the grosser mental ills, psychiatry has reached out to follow mental illness to its origins, and thus finds itself faced with definite obligations in the community. Social work, growing up in the midst of the community and of family life, has come increasingly to recognize that assistance with the concrete economic and environmental problems that confront people is frequently not enough, and that an understanding of the forces that move within people, with the aid of insights afforded by psychiatry, is an essential part of intelligent service to families and individuals. To-day, with their respective professional skills and functions, psychiatry and social work are brought closely together in the common community task of improving the quality of living.

# MENTAL-HYGIENE CONSIDERATIONS IN THE CARE OF CONVALESCENT CHILDREN *

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AN opportunity was recently presented for carrying nursery-school techniques into two hospitals. To determine the natural limitations and possibilities within such situations, two trained nursery-school workers [1] spent 66 mornings making detailed observations in children's wards. The present article presents some of the facts and suggestions which grew out of that study and which may be useful to those interested in the social and play outlets of convalescent children, both within hospitals and in homes. They seem especially significant since specialists are recognizing more and more that mental- as well as physical-health factors are important considerations in the lives of convalescents.

The present observations were carried on in two quite different hospital situations—one a county hospital with a necessarily crowded nursing schedule and no staff provisions for play; the second a more adequately staffed and financed hospital, with a play supervisor and definite play facilities. Despite these differences in play and social opportunities, the findings in the studies of the two hospitals were so similar that there seems no need for giving them separate consideration in the following discussion.

The findings were based upon 292 observations made between 9 and 12 in the morning. The children observed ranged from one and a half to eight and a half years in age. The median age was between three and four years. Observations

* This study was conceived and sponsored by Rose H. Alschuler. It was made possible through the splendid coöperation of the doctors and nurses in the respective hospitals and through facilities afforded by the I.E.R.C. and the W.P.A. Emergency Nursery Schools, Project of Chicago.

[1] The two workers, who gave unstintingly of their time and efforts, were Molly Sanders and Margaret Egan.

were made in the morning because it is a relatively free part of the day so far as the child is concerned.[1]

In most hospitals it is the nurse who is in most frequent contact with the ill child and who must meet his mental as well as his physical needs. For this reason we were anxious to discover how much time the nurse has to give to such activities. An attempt was, therefore, made to determine how many and what kinds of contacts the nurses in these two hospitals initiated with the children during the 9 to 12 period. The observational records indicated that the nurses in each of the two hospitals initiated only from three to four direct contacts with each child in the ward during this time. It was also found that these nurses made approximately three medical and routine contacts with each child to every social contact.[2]

Furthermore, the nurses seemed to be definitely engaged in other duties during the time that they were in the ward and not in contact with the children. If the above results are typical, it would seem that nurses have comparatively little time to devote entirely to the social or play interests of the sick child. Practically all of the limited time they do have is absorbed by necessary routine and medical attention. This suggests that any procedures that nurses might follow in meeting children's play and social interests would be feasible only in as far as they did not involve extra time demands.

The observations suggested that nurses, or any adults who associate with sick children, can meet many of the convalescent child's social needs, such as his need for learning to coöperate and for learning to adjust to other people, through routine and medical contacts. They will need in such cases to give

[1] The exact methods used in the study, the reliability, the description of types of illness and stages of convalescence are contained in an unpublished manuscript. An attempt was made to relate types of illness to the points discussed below, but no outstanding differences were found. Possibly if the children had not all been far along on the road to recovery, this would not have been the case. Further data may be obtained by communicating with the author.

[2] The term *social* is here used to cover all contacts not of medical or routine nature. These include "playing with the child," "reading to the child," "providing play materials." The term *medical* is applied to such contacts as "giving medicine," "dressing wounds," "taking temperatures." *Routine* contacts include "washing or bathing the child," "helping the child dress," "attending to elimination needs," "straightening the bed."

serious thought to the ways in which washing, bathing, dressing the child, making the bed, giving medicine, and so forth, can contribute to the child's general interests and welfare.

One means of enriching the value of the above situations is in permitting and encouraging self-help. The young child really enjoys the feeling that he is a partner to whatever task is going on. Our observations revealed distinct social values in self-help situations. Self-help tends to encourage the child to develop a more coöperative attitude toward the adults in contact with him. Observations were made of 86 instances in which children resisted physical contacts initiated by the nurses. It was discovered that 92 per cent of this resistance occurred in situations in which the nurses did not give the children a chance to help themselves. In the 237 situations in which nurses permitted self-help, only 7 cases (3 per cent) of resistance were found.

Self-help has other social values which are too far-reaching to stand out in observations made within a relatively short length of time. Most of us are aware of the fact that children with a history of illness are liable to be overdependent. We do not so readily realize that overdependence is not an inevitable consequence of illness. Rightly considered, the convalescent period should serve just as much to help the child accept normal responsibility as it serves to help him regain physical energy. Encouragement of self-help during convalescence is a key to rebuilding self-reliance on the part of the child.

Even though she recognizes these points, the nurse, being human, is apt to adopt the attitude of many mothers: "I haven't the time to let him help himself. I'd better do it myself." It would seem from our observations that that statement has little validity in the hospital situation. Indeed, in one hospital to which our workers had access (not one of the two on which these observations were based), nurses were encouraged to permit self-help as a time-saving device. In this hospital the nurse gave each child in turn the necessary start or initial assistance so that eventually all the children were doing routine things at once and time was actually gained. The previous discussion also indicates that self-help would be a time-saving device in its reduction of resistance.

It is obvious that if the nurse or other adult is to encourage self-help, she must know something of expectancies at different age levels—*i.e.*, at what age the child can be expected to feed himself, button his clothing, have bowel and bladder control, and so on. Information on this point for the well child can be obtained from several sources.[1] Expectancies are usually not so high for the ill or convalescing child as for the well child. Just what they would be, can best be worked out in individual cases after consultation with the child's physician. All adults who work with ill children, however, should be thoroughly familiar with the expectancies of well children at different age levels.

The conversation that accompanies the contacts of adults with the child may serve as a second important means of enriching medical and routine contacts. The following findings are based on verbal contacts between children and nurses which did not happen to occur while the nurse and child were in direct physical contact. They did, nevertheless, reveal some suggestive findings.

The two nursery-school workers in their set of observations, which may or may not be typical, found that from 20 to 25 per cent of the conversation initiated by nurses with the children consisted of negative commands such as, "Don't jump like that. You're not supposed to," "Stop pounding on the wall," and so on. Such statements indicate the absence of a constructive attitude. If the contacts of adults with the child are to be meaningful, they should stimulate new and acceptable interests and activities rather than call attention to undesirable behavior. A few helpful suggestions as to acceptable activity can do much more to prevent the jumping and wall-pounding than can all the "don'ts" in the world.

The observation also indicated that between 1 and 2 per cent of the conversation initiated by nurses expressed

[1] For example, Rose H. Alschuler's *Two to Six* (New York: William Morrow and Company, 1933) gives information (pp. 26–50) on expectancies for dressing, sleeping, eating, toilet, social development. For physical, motor, mental, emotional, social and play expectancies, see Chapter 2, pp. 23–33, of *Nursery School Procedure* by Josephine C. Foster and Marion L. Mattson (New York: D. Appleton and Company, 1929). See also the *Manual of Nursery School Practice* of the Iowa Child Welfare Research Station (State University of Iowa Bulletin No. 730, 1929) for a discussion of self-help expectancies (pp. 170–77).

approval, whereas from 9 to 10 per cent involved scolding or criticism. (This would be approximately 30 to 35 per cent if we add to it the negative commands indicated above.) Here, again, the need for a constructive point of view is evident. Encouragement of good behavior is as important as positive suggestions in guiding the child's interests into approved channels.

A third very desirable accompaniment of the above attitudes is expectancy of good behavior. Three per cent of the verbal contacts initiated by nurses during the observations reflected undesirable expectancies; as, for instance, "Don't put that toy in your mouth," to a child who had not yet done so, or "You'll probably throw these toys on the floor anyhow," to a child who was just being provided with play materials. No voiced examples of desirable expectancies on the part of any of the nurses were observed.

If the preceding suggestions are followed, and social development is sought in medical and routine contacts, then the distinction between "medical," "routine," and "social" contacts obviously does not hold. There will still be occasions, however, when the nurse and child will be in contact for reasons in which neither medication nor routine attention are paramount. The term "social" has been reserved for this type of situation. What types of activity do these "social" contacts include? How can they be most advantageously used for the mental health of the child? Do they provide any basis for developing an adequate play program?

The two observers found that from 42 to 44 per cent of these "social" contacts initiated by nurses had to do with providing play materials, from 30 to 31 per cent involved fondling and caressing, from 15 to 20 per cent involved active play with the child, and the remainder were too varied to permit of classification.

The provision of play materials was clearly the most frequent "social" contact initiated by nurses. This finding gains significance if we remember that nursery-school programs in general are based on a belief that adults should provide the proper play materials and then leave children relatively free to develop their own play interests and activities. This type of program, in which materials are provided

and undirected play is encouraged, is in keeping with hospital demands and limitations—*i.e.*, with (1) the limited time that the nurse has at her disposal and (2) the need for providing play interests that will continue when the nurse is out of the room. Strangely enough, it is a possibility which is so simple that it has seemingly escaped the attention of many of the nurses and student nurses with whom we came in contact. Play provisions to them meant group play under close adult supervision, if not adult participation. If these nurses had realized that the simple provision of well-selected materials could, in itself, have provided the basis for an adequate play program, they would undoubtedly have approached these tasks with a great deal more interest and efficiency.

So far only the contacts initiated by nurses have been considered. An analysis of children's demands should reveal something of their needs and hence have a bearing on the above points.

It was found that 66 per cent of the children's demands in the one hospital and 31 per cent of their demands in the other hospital[1] were for social or play opportunities. "Social" requests were exceeded only by demands for a drink and those concerned with urination.

Sixty-nine per cent of the children's social demands were requests for play materials, 17 per cent were requests for play with the nurse, and 14 per cent were too varied to permit of classification. If we believe that children's requests are indications of their needs, then the predominance of requests for play materials is further evidence of the need for and the value of a program in which play materials are provided and the child is left alone to develop his own play interests.

Our study revealed another important value of play during the sick period. It is a recognized fact that a long confinement in bed often makes for such self-manipulation as thumb-sucking, masturbation, finger play, and so forth. This was, in fact, the most common behavior problem presented in the present set of data. When these same children who presented self-manipulatory habits were given adequate play materials,

[1] This is the only point on which the two hospitals varied to any extent. The difference is undoubtedly due in large measure to the presence of a play supervisor in the second hospital.

it was found that this undesirable behavior decreased in a ratio of 6 to 1—in other words, a decrease of 839. Such undesirable habits as excessive physical activity also decreased markedly when adequate play materials were provided.

If nurses or other adults are to meet the child's play needs adequately through the provision of proper play materials, they will need to familiarize themselves with play interests and needs at various ages in relation to various types of illness and the restraints involved therein.[1] Knowledge of play interests and needs in relation to various types of illness and restraints is still in a very rudimentary stage. It can usually be gleaned to better advantage from observations and conferences with play supervisors in the few institutions that provide such services than from any literature available at the present time.

If hospitals are unable to supply play materials, they can often be obtained from other sources. Nurses should be aware of these possibilities. One way of securing play materials is to request such service from a local organization as part of its philanthropic program. When specific requests for certain kinds of materials are made, the value of such services from the outside can be materially enhanced.

A second means of securing play materials (especially if each child has some play space, such as a bed apron with pockets, a bag for toys, a drawer in a bed table, a cupboard shelf, which is all his own) is to ask each child's parent to bring two or three specified toys for the child during his hospital stay. This method can often be worked into a technique for educating the parents themselves.

A final method which nurses can use in securing play materials is to take advantage of the crude materials that the hospital can provide. Picture cards from baking supplies, uniform sheets of cardboard from the laundry which can be made into all sorts of things, spools from medical service, various types and sizes of boxes from all departments are a

[1] See Alschuler and Foster and Mattson *op. cit.* See also *Nursery Education*, by William E. Blatz, Dorothy Millishamp, and Margaret Fletcher (New York: Morrow and Company, 1936) for discussions on planning the free-play period, on adult procedures in the free-play period, and on the uses of separate pieces of play equipment.

few of the many things that can be utilized as valuable play materials.

These suggestions are offered as rather general guides for the adult who is interested in the all-around welfare of the convalescing child. It is apparent that in the regular course of medical and routine contacts the nurse or other adult attending the sick child can greatly enhance his social experiences and development. It is also evident that the nurse or other adult can meet the child's play needs adequately with little, if any, extra time and attention, if she will accept as part of her routine the provision of suitable play materials. Both of these points seem particularly worth consideration since they add to the enriched development of the child without materially increasing the work or responsibility of the adult.

# THE PRISON PSYCHIATRIST *

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WITH the growth of the mental-hygiene movement, and the realization that crime, besides being a sociological problem, is a psychiatric problem as well, has come the introduction of psychiatrists into prisons. At the turn of the century the prison physician was already being called upon to decide whether inmates were mentally unbalanced to such a degree that they should be transferred to prisons especially constructed for the criminal insane, but he could not be considered a trained psychiatrist. Nor was there any general acceptance of the point of view that the insane convict should receive treatment (institutions for the criminal insane were merely thick stone walls with barred windows designed to keep the "mad" digressor from ever resuming any place in society) or that the psychiatric and sociological factors behind the incarceration of the "normal" inmate should be analyzed and used as a basis for dealing with him, in order that he might be a better citizen upon his release.

But shortly after the development of modern psychiatry had begun with Kraepelin's classifications and studies, and with the modification of psychiatric techniques that resulted from the studies of Freud, Adler, and others whose names are associated with psychiatric dynamics as we see them to-day, two tendencies made their appearance, culminating about ten years ago in the introduction of trained psychiatrists into the prison system. These two lines of psychiatric progress arose by way of entirely different interests. One of them was the preventive angle developed by The National Committee for Mental Hygiene at the instigation of Clifford Beers, and the other arose from the realization that the work of the alienist in a court is not as simple as it had once seemed to be.

The work of the National Committee included the develop-

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ment of child-guidance clinics. These clinics not only attempted to prevent mild and serious mental ailments in the general population, but led eventually to the realization that the proper treatment of pathology observed in childhood might mean the prevention of pathology in maturity. Hence, such early institutions as the Juvenile Psychopathic Institute in Chicago, founded by William Healy, and the Judge Baker Foundation in Boston, which he later headed, have given rise to rather extensive child-guidance programs in connection with juvenile courts. On the other hand, the problems of the court alienist have emphasized the need for sociological and psychiatric study of the offender, making it obvious that segregation is not the whole answer to the problem of crime, but that study and treatment must be carried on before segregation, or in place of segregation, in prison.

The early development of prison psychiatry was carried out by a few individuals who were appointed as prison psychiatrists to work directly under the warden, often without the aid of guidance from any state department that might have an interest in psychiatric treatment and care. Later, these psychiatrists became integrated into larger state systems, and we now have systematic administration of the problem by the United States Federal Government as well as the governments of most of the more populous states. In Illinois, for instance, there is an officer who ranks on a par with the head of the department of charities, who is known as the state criminologist. According to recently passed statutes, prison psychiatrists, under his direction, have the power and duty of segregating first offenders; of recommending physical- and mental-health treatment for all prison inmates; and of aiding the parole board in considering the psychiatric problems involved when a man comes up for release. These services are rendered not only in institutions for the hardened or mature offender, but also in the institutions for delinquent children. The problems in the institutions for delinquent children are peculiar to themselves and will not be considered here, but the problems, duties, responsibilities, and aims of the prison psychiatrist can be discussed in a general and brief way, so that those who do not often have an opportunity to get behind prison walls may understand what is being attempted.

The uniqueness of the problems in this situation must be considered first: From the beginning of the prisoner's delinquent career, every individual with whom he comes in contact must be considered a source of suspicion. Particularly is this true of policemen and other officers of the law and of justice. It is essential, therefore, that the psychiatrist be identified with no law-enforcement agencies. Yet in court the psychiatrist is often made to bear the brunt of the conviction and the subsequent punishment. His recommendation is often read in open court by the judge, who may turn to the prisoner and say, "You see what the doctor says about you. You are a bad egg, and there is nothing that can be done for you." So even before he reaches prison the convict feels that a psychiatrist is not one who is to be trusted. All of the efforts that he may make in prison to show his interest in the offender's subsequent career and in a treatment program for him may bear no fruit just because of this attitude brought about in the convict by the way he is treated at court. He learns even there that the psychiatrist is to be considered an officer of the law. As a convict once said to me, "The 'bug doctor' is a 'screw'[1] and I wouldn't trust him as far as I could throw a mountain."

Yet without the coöperation of the convict, the psychiatrist is practically helpless. Through certain techniques he can cause the convict to become very angry at him; he can play upon his emotions; he can cause resentment; and in all these ways he can get a superficial impression of the convict's make-up which can be supplemented by careful studies of the convict's background and behavior before he came into the prison. But unless he can secure the convict's coöperation so that he will express his innermost thoughts and desires and be relatively honest, the psychiatrist is helpless.

Another difficulty must also be noted. In the majority of convicts in prison, there is a tendency never to speak frankly under any condition for fear that the admission of guilt or the honest expression of opinions will be used against them. Experienced prison psychiatrists frankly admit that if an honest man were to be put into the prison situation, he would, out of self-protection, be forced to deny most of his semi-

[1] Guard or turnkey.

legitimate activities for fear that they might be misinterpreted as contrary to law. For this reason it is necessary for the psychiatrist to convince the whole prison population that he will treat each individual with fairness, and that, so far as he is permitted to do so by law, he will keep details to himself.

Many psychiatrists feel it is not necessary for the prisoner to admit whether the crime for which he was sent to prison was actually committed by him, assuming that the decision of the court is correct and considering the convict's emotional background and ideation without this knowledge. I have not found this to be the case. If one does not know exactly how the convict feels about the crime in question, one cannot diagnose or treat. For instance, if the convict is sent to prison falsely, he will be much more resentful toward the law than if the crime had been actually committed by him, although it must be admitted that most hardened offenders are resentful, feeling that it is society that made them criminals rather than any choice on their own part. In order to comprehend the significance of this attitude, one must realize that almost all criminals, both before and after conviction, will deny, as a matter of policy, the fact that they have committed a crime. The more hardened they are, the more likely they are to deny, and to impress the psychiatrist with the truth of their denial.

In order that the psychiatrist may not fall too easily into this trap, as he is likely to do if he is basing his reactions on superficial statements and emotions, it is necessary that he have the man's background and the nature of the crime thoroughly fixed in his mind. From experience I have found that the best way to do this is to have assisting me a sociologist who knows intimately the offenders of the particular part of the city from which the prisoner comes. If the prisoner seems to have hung around with most of the "bad eggs" in that community and to have frequented places where the hoodlums hang out, every statement of innocence must be looked upon with a great deal of suspicion. In such a city as Chicago, probably the best studied city so far as community activities are concerned, it is quite possible to know who the local hoodlums are in almost every neighborhood, to find out how well identified with them the convict is, and often to

secure an admission from him that he was associated in some way with those who are unquestionably tied up in criminal activities. If, on the other hand, his life has been blameless, his school achievement, his work record, and his family life have been without question, the records of the trial should be examined to see just what type of evidence was produced against him. As Borchard showed in his book, *Convicting the Innocent,* even in this country it is possible wrongly to convict a man.

In addition to obtaining information about the convict by a study of his background, the prison psychiatrist must study the man himself. He must play upon his interests and must treat him as an individual would be treated outside of the prison walls. This often causes a great deal of friction between him and the prison officers and sometimes between him and the community when the news gets out that the psychiatrist is "pampering" certain convicts. Nevertheless, in order to secure accurate information, the situation must be met on a diagnostic and therapeutic basis and not as a matter of punishment or trying to "get" something on the offender.

It must be admitted that, even under these circumstances, the problem is difficult for, as we have pointed out, the convict is often suspicious and there is nothing a psychiatrist can do to break down this suspicion in the most hardened type of offender. Very often such a one can see no purpose in being cured. In the back of his mind remains the idea that he is going out to commit other offenses, and reasoning with him or telling him how much more pleasant life is within the law seldom produces a favorable reaction and does not necessarily make him more coöperative. Many important questions of criminal psychology come up at this point. For instance, why should a man who can earn one hundred dollars a week by the use of the revolver take a job as clerk in a store for eighteen dollars, particularly if he is a young man and the risk gives him a certain amount of pleasure and compensates for certain inferiority feelings which he may have?

One way in which the psychiatrist may get the inmates to coöperate with him is by the kindly administration of the little psychiatric-hospital service which is carried on in the

prison ground. If the men know that when they become mentally sick or have neurotic episodes, they will be treated as patients outside the prison would be, the attitude of the whole prison population becomes distinctly in favor of the psychiatrist. Often the men will try to take advantage of him and to use his little hospital as a place in which to serve some "easy time," but more often the inmates themselves will try to prevent this, so that rooms will be available to insure that those who are really sick will get proper care and treatment. Sometimes it is necessary to enroll many of the more intelligent and more coöperative inmates in the maintenance of the hospital in order to give occupational therapy, hydrotherapy, and even psychotherapy. Under such conditions, these inmates can develop a very favorable attitude toward the examiner.

If the psychiatrist builds up within the prison walls the idea among the inmates that he is trustworthy and aims to be helpful, he serves a very great purpose both in adjusting the inmates toward their future environment before they leave and in helping with discipline. In many prisons where there is not a full-time psychiatrist or where there is an inadequately trained one who is interested rather in fulfilling the official duties of his office than in treatment, a situation arises in which the psychiatrist is distinctly an administrative officer. He recommends punishment for the inmates, such as solitary confinement; he denies their good-time allowances, and suggests to prison officials what should be done for mass discipline. Such men are considered ideal from the standpoint of the prison officials, but they get poor response from the inmates. On the other hand, the psychiatrist who is interested in treatment very often has the rôle that, in a prison where the psychiatrist is inadequate, is delegated to the minister or priest. The inmate must have a confidant, and if this confidant is in a position to do him some good and to help the prison administration, he is a person who is well worth his keep and a high salary.

The amount of help that can be given by the psychiatrist to a prisoner before release is always a matter of question. If he is in charge of the school placement, if he can devise occupational opportunities that will enable the prisoner to adjust

after his release, he can begin to be sanguine. However, after release the prisoner has additional problems to contend with —namely, the attitude of the general public in not wanting to employ a convict, the tendency of the police to hound an ex-convict and to gaze upon him with suspicion at all times, and the inmate's own feelings of inferiority and defeat. For this reason it has proved an interesting experiment, where it has been tried, for the psychiatrist to continue his contact with the convict after release. Because of the fact that so many psychiatrists in prisons are overworked, however, this is a difficult procedure to initiate.

Bearing these facts in mind, we may briefly summarize the rôle of the prison psychiatrist as follows:

1. His purpose should be to establish such a relationship with the convicts that they will have utter trust in him and will back him up in handling other and newer convicts. At the same time he should build up the relationship between the officers of the prison and himself, so that he may be in a position to help the convict as well as the officers.

2. He must not forget that he has a definite responsibility toward society. He must aid the parole board in preventing the release of men who will never become adjusted, at the same time being in a position to make release available to the more promising men as soon as possible and at the time when they are most likely to get along in society. He has, of course, the duty toward society of advising the prison administration of the treatment that the convict should receive in order to make his readjustment to society as promising as possible when he is released.

3. He should make it clear to the officers that he is not a disciplinarian, but that he will be very glad to coöperate in making plans for any man who is troublesome, and, if such a man needs psychiatric treatment or special attention, to make such treatment or attention available in a way that will best meet the needs of the convict and aid the officers.

4. He should be the friend, confidant, and therapeutic officer to whom the convict can go at any time, to receive any treatment that he needs and to have his social and psychiatric problems adjusted for him. These tasks can be accomplished only on two conditions: 1. The psychiatrist must be ade-

quately trained, with a personality that is in keeping with a humane and modern attitude toward the prisoner. His minimum training should consist of both mental-hospital work and out-patient-clinic work and, before he is placed in charge of a prison clinic, he should have some experience as a subordinate to an experienced prison psychiatrist. So far as his personality is concerned, we have found that a cheerful individual who has it "put over" on him occasionally is more helpful than the ascetic, official, clever psychiatrist, whose cleverness often defeats his purpose. 2. The psychiatrist should be provided with adequate help both from trained personnel and the inmates. His trained personnel should include a sociologist who is keenly aware of the problems of the community from which the convict comes, as well as of the attitude of the judges and court, and who is able to sift evidence so that he may save the psychiatrist time. Associated with the psychiatrist should be a psychologist who can not only administer the usual intelligence test, but also test aptitude and do personality analysis, so that the psychiatrist may have some facts upon which to base his study.

As to the convict personnel, more than anything else there is need of a liaison officer, one who is so prison wise that the convicts trust him and yet who either is personally interested in the examiner or feels that something can be done for the other prisoners, so that he will, without violating confidences, put the psychiatrist in the way of doing his very best for the inmates. With him should be certain others who need not necessarily stand in so well with the convict personnel, but who are sufficiently intelligent and sufficiently versed in the ways of crime to be able to interpret to the psychiatrist from their own experience how the typical convict thinks. With these points of view and with this type of personnel to help him, the prison psychiatrist should be able to make some slight inroads into the problem of crime.

Sometimes the psychiatrist will find among the prison population certain convicts whose cases are not up for consideration, but who, by frank discussion, will enable him to understand the thought processes of both inmates and unconvicted criminals. But in this procedure I have found that it is necessary to be most circumspect, so that these inmates

will not learn what the psychiatrist's reaction is concerning the prison officers or other inmates or even what his general attitude is about the law.

In general, a psychiatrist whose integrity is unquestioned, but who has a helpful point of view and adequate training, should, by his research, his diagnoses, and his therapy, make a distinct inroad into the crime problem. The application of the techniques of medicine and the standards of the medical practitioner through the ages have already begun to raise criminology and the treatment of criminals from the depths to which authorities agree it has sunk at least one step higher —a short step perhaps, but nevertheless a perceptible one.

# THE EXPECTATION OF MENTAL DISEASE IN NEW YORK CITY IN 1930 *

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MALES and females in New York City had expectations of mental disease of 5.72 and 5.55 per cent, respectively, in 1930. That is, one of every 17.5 males, and one of every 18.0 females in New York City may expect to be treated in an institution for mental disease in New York State sometime during their lives. The expectations exceed those for the state of New York as a whole, in 1920, in which year the expectations for the state were 4.7 and 4.4 per 100 males and females, respectively.

In the present study the expectations of mental disease are based on the average annual rates of first admissions from New York City to all institutions for mental disease in New York State during the three fiscal years ended June 30, 1931, and the average annual rates of mortality in New York City during the same interval. The institutions include the state hospitals for both the civil and criminal insane, and the licensed institutions for the treatment of patients with mental disease. The statistics of first admissions do not include voluntary cases received in the latter institutions, but do include patients received on a physician's certificate. The construction of the tables of expectation may be described briefly as follows:

The computation of the expectation of mental disease requires rates of first admissions and rates of mortality at each year of life. Both sets of rates were computed in the same manner and consist, essentially, in the application of methods utilized by George King in the construction of the English life table, 1901 to 1910. This method consists in obtaining pivotal values at ages seven, twelve, seventeen, twenty-

* A contribution to the study of mental disease in the metropolitan area of New York City conducted jointly by The National Committee for Mental Hygiene and the United States Public Health Service.

two, etc. From these pivotal values of population, deaths, and first admissions, we obtain corresponding central rates of mortality, and of first admissions. These are converted into probabilities in the usual manner. The intervening rates for single years are then derived by means of osculatory interpolation. In the case of rates of first admissions, the lowest reliable rate was obtained for age twelve. Rates for lower ages were not estimated in view of the fact that there is practically no mental disease under ten years of age, and the exclusion of these rates cannot, in any case, have a significant effect upon the derived expectations of mental disease. Owing to the small totals of first admissions at the advanced ages (*i.e.*, over ninety-two) the calculated pivotal rates were unreliable and had to be replaced by smoothed values. These were adjusted on the basis of constant second differences. Because of the small totals involved at the higher ages, these rates, even if somewhat in error, cannot have any significant effect upon the expectation of mental disease.

Rates of mortality through the first five years of life were obtained from a consideration of births and deaths, and the adjustment of these totals in relation to the census totals of 1930. Remaining rates up to the twelfth year were obtained by the application of LaGrange's interpolation formula. Rates of mortality above age ninety-two were obtained by interpolation on the assumption that the rate of mortality was unity at age one hundred and twelve.

The subsequent construction was the same as that described in the paper on the expectation of mental disease, by H. M. Pollock and B. Malzberg.[1] In brief, this consists in determining the total at any exact age who are both alive and sane and calculating the expected total of annual first admissions at that age and the number remaining sane who will die during the interval. By summing the total of first admissions at any age (X) and at all higher ages, to the end of the table, and dividing this total by the number who were alive and sane at exact age (X), we obtain the expectation of mental disease at that age. For example, among males there were 89,585 who were alive and sane at twelve years of age. During this year

[1] See MENTAL HYGIENE, Vol. 13, pp. 132–163, January, 1929. This paper appeared also in the *Psychiatric Quarterly*, Vol. 2, pp. 549–79, October, 1928.

there were four first admissions. At this and all subsequent ages there were 5,718 first admissions. This total, divided by 89,585, gives an expectation of mental disease of 6.38 per cent at twelve years of age. That is, of every 100 persons aged exactly twelve years, 6.38 will be treated in an institution for mental disease in New York State before they die.

Table 1 summarizes the average annual rates of first admissions from New York City in 1930.

TABLE 1. AVERAGE ANNUAL RATES OF FIRST ADMISSIONS FROM NEW YORK CITY PER 100,000 CORRESPONDING GENERAL POPULATION, TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1929 TO 1931

| *Exact age in years* | *Males* | *Females* |
|---|---|---|
| 0 | ..... | ..... |
| 5 | ..... | ..... |
| 10 | ..... | ..... |
| 15 | 37.75 | 25.77 |
| 20 | 79.18 | 55.13 |
| 25 | 91.14 | 72.55 |
| 30 | 94.46 | 82.35 |
| 35 | 104.90 | 90.21 |
| 40 | 113.30 | 103.16 |
| 45 | 121.64 | 108.48 |
| 50 | 134.66 | 110.46 |
| 55 | 139.04 | 116.42 |
| 60 | 174.21 | 131.32 |
| 65 | 215.09 | 164.81 |
| 70 | 286.61 | 229.46 |
| 75 | 422.96 | 360.23 |
| 80 | 617.33 | 459.51 |
| 85 | 866.84 | 646.64 |
| 90 | 1,168.56 | 942.53 |
| 95 | 1,519.59 | 1,162.84 |
| 100 | 1,917.08 | 1,438.88 |

The general picture is the same for both sexes. The rate is a minimum at the youngest age level and rises steadily with increasing velocity at intervening ages to a maximum in old age. Among males there was a rate of 37.75 per 100,000 population at fifteen years of age. The rate rose to a maximum of 1,917.08 at one hundred years. Females had lower rates than males. Among them there was a minimum of 25.77 at fifteen years, and a steady growth to a maximum of 1,438.88 at one hundred years.

Table 2 summarizes the expectations of mental disease, which are shown in detail in Tables 3 and 4 (pages 285–90).

Males had a higher expectation than females throughout life. At birth the expectations were 5.72 and 5.55 for males and females, respectively. Both showed similar trends. Among males the expectation rose to a maximum of 6.39 at thirteen and fourteen years. This was followed by a steady

TABLE 2. NUMBER BECOMING MENTALLY ILL DURING REMAINDER OF LIFE OF 100 ALIVE AND SANE AT SPECIFIED AGE, NEW YORK CITY, 1930

| *Exact age in years* | *Males* | *Females* |
|---|---|---|
| 0 | 5.72 | 5.55 |
| 5 | 6.29 | 5.99 |
| 10 | 6.36 | 6.04 |
| 15 | 6.38 | 6.05 |
| 20 | 6.18 | 5.93 |
| 25 | 5.88 | 5.73 |
| 30 | 5.55 | 5.46 |
| 35 | 5.23 | 5.16 |
| 40 | 4.88 | 4.83 |
| 45 | 4.63 | 4.48 |
| 50 | 4.34 | 4.19 |
| 55 | 4.14 | 3.94 |
| 60 | 4.08 | 3.81 |
| 65 | 4.04 | 3.71 |
| 70 | 4.14 | 3.71 |
| 75 | 4.23 | 3.71 |
| 80 | 4.33 | 3.64 |
| 85 | 4.43 | 3.84 |
| 90 | 4.53 | 3.94 |
| 95 | 4.00 | 3.30 |

decline to an expectation of 4.04 per cent at sixty-three to sixty-five years. There is then a significant change in trend. The expectation rose through the ninetieth year, reaching a rate of 4.53 at the latter age. This is undoubtedly due to the increasing prevalence of mental disorders associated with arteriosclerotic disease in the past decade, disorders which increase rapidly with advancing age. First admissions with psychoses with cerebral arteriosclerosis are increasing rapidly in frequency, and at present are exceeded only by those with dementia praecox. After age ninety, the expectation of mental disease decreases once more. The table is closed at the age where there is the last whole number in the expected total of mental cases. Theoretically, of course, the expectation never

becomes zero, for at each age until the extinction of the whole population there is a probability of mental disease.

Among females the expectation of mental disease grew from 5.55 per cent at birth to a maximum of 6.06 at twelve to fourteen years. The expectation then decreased to 3.70 at sixty-six to sixty-eight years, rose slightly to 3.72 at seventy-two to seventy-four, and then decreased to 3.64 at seventy-nine to eighty years. The expectation then grew to 3.96 at eighty-eight and eighty-nine years. As in the case of the males, this upward trend undoubtedly is associated with arteriosclerotic disorders at the older ages. The upward change occurs earlier, however, than in the case of the males. After age eighty-nine the expectation gradually decreases.

Some simple applications may be made of the tables of expectation of mental disease. On April 1, 1930, there were 51,178 males and 49,220 females in New York City under one year of age. The expectations of mental disease at birth in 1930 were 5.72 and 5.55 for males and females, respectively. Accordingly 2,927 of the males and 2,732 of the females may be expected to become patients with mental disease before they die. We may consider the school group as those between six and sixteen years of age, inclusive. There were 637,828 males and 627,194 females in these age categories on April 1, 1930. Of the males, 40,559 will develop a mental condition necessitating hospitalization; the corresponding total for females is 37,937.

TABLE 3. EXPECTATION OF MENTAL DISEASE AMONG MALES IN NEW YORK CITY, 1930

| Age interval, years | Of 100,000 persons born alive | | Rate of mental disease per 100,000 | Rate of mortality per 1,000 | Expectation of mental disease |
|---|---|---|---|---|---|
| Period of lifetime between two exact ages | Number alive and sane at beginning of age interval | Number becoming mentally ill in age interval | Number becoming mentally ill during age interval among 100,000 alive and sane at beginning of age interval | Number dying in age interval per 1,000 alive at beginning of interval and remaining sane during interval | Number becoming mentally ill during remainder of life of 100 alive and sane at beginning of age interval |
| $x$ to $x+1$ | $l_x$ | $i_x$ | $100{,}000\ s_x$ | $1{,}000\ q_x$ | $t_x = \frac{\sum_x^{104} i_x}{l_x}$ |
| 0— 1 | 100,000 | .. | ..... | 68.27 | 5.72 |
| 1— 2 | 93,173 | .. | ..... | 10.56 | 6.14 |
| 2— 3 | 92,189 | .. | ..... | 5.88 | 6.20 |
| 3— 4 | 91,647 | .. | ..... | 4.15 | 6.24 |
| 4— 5 | 91,267 | .. | ..... | 3.69 | 6.27 |
| 5— 6 | 90,930 | .. | ..... | 3.14 | 6.29 |
| 6— 7 | 90,644 | .. | ..... | 2.77 | 6.31 |
| 7— 8 | 90,393 | .. | ..... | 2.27 | 6.33 |
| 8— 9 | 90,188 | .. | ..... | 1.88 | 6.34 |
| 9—10 | 90,018 | .. | ..... | 1.80 | 6.35 |
| 10—11 | 89,856 | .. | ..... | 1.54 | 6.36 |
| 11—12 | 89,718 | .. | ..... | 1.48 | 6.37 |
| 12—13 | 89,585 | 4 | 4.70 | 1.59 | 6.38 |
| 13—14 | 89,439 | 12 | 12.92 | 1.71 | 6.39 |
| 14—15 | 89,274 | 22 | 24.60 | 1.90 | 6.39 |
| 15—16 | 89,082 | 34 | 37.75 | 2.13 | 6.38 |
| 16—17 | 88,858 | 45 | 50.38 | 2.36 | 6.35 |
| 17—18 | 88,603 | 54 | 60.51 | 2.57 | 6.32 |
| 18—19 | 88,321 | 60 | 67.98 | 2.74 | 6.28 |
| 19—20 | 88,019 | 65 | 74.14 | 2.91 | 6.23 |
| 20—21 | 87,698 | 69 | 79.18 | 3.07 | 6.18 |
| 21—22 | 87,360 | 73 | 83.32 | 3.21 | 6.13 |
| 22—23 | 87,007 | 75 | 86.77 | 3.34 | 6.07 |
| 23—24 | 86,642 | 77 | 89.21 | 3.44 | 6.01 |
| 24—25 | 86,267 | 78 | 90.51 | 3.51 | 5.94 |
| 25—26 | 85,886 | 78 | 91.14 | 3.57 | 5.88 |
| 26—27 | 85,502 | 78 | 91.57 | 3.66 | 5.82 |
| 27—28 | 85,111 | 79 | 92.28 | 3.79 | 5.75 |
| 28—29 | 84,710 | 79 | 93.12 | 3.97 | 5.68 |
| 29—30 | 84,295 | 79 | 93.77 | 4.19 | 5.62 |
| 30—31 | 83,863 | 79 | 94.46 | 4.44 | 5.55 |
| 31—32 | 83,412 | 80 | 95.42 | 4.71 | 5.49 |
| 32—33 | 82,940 | 80 | 96.87 | 5.01 | 5.42 |
| 33—34 | 82,445 | 82 | 99.08 | 5.33 | 5.36 |
| 34—35 | 81,924 | 83 | 101.88 | 5.66 | 5.29 |
| 35—36 | 81,378 | 85 | 104.90 | 6.03 | 5.23 |
| 36—37 | 80,803 | 87 | 107.75 | 6.45 | 5.16 |
| 37—38 | 80,195 | 88 | 110.02 | 6.91 | 5.09 |
| 38—39 | 79,553 | 89 | 111.53 | 7.42 | 5.02 |
| 39—40 | 78,874 | 89 | 112.51 | 7.96 | 4.94 |
| 40—41 | 78,158 | 89 | 113.30 | 8.56 | 4.88 |

TABLE 3. EXPECTATION OF MENTAL DISEASE AMONG MALES IN NEW YORK CITY, 1930 (Continued)

| Age interval, years | Of 100,000 persons born alive | | Rate of mental disease per 100,000 | Rate of mortality per 1,000 | Expectation of mental disease |
|---|---|---|---|---|---|
| Period of lifetime between two exact ages | Number alive and sane at beginning of age interval | Number becoming mentally ill in age interval | Number becoming mentally ill during age interval among 100,000 alive and sane at beginning of age interval | Number dying in age interval per 1,000 alive at beginning of interval and remaining sane during interval | Number becoming mentally ill during remainder of life of 100 alive and sane at beginning of age interval |
| $x$ to $x+1$ | $l_x$ | $i_x$ | 100,000 $s_x$ | 1,000 $q_x$ | $t_x = \frac{\sum_{x}^{104} i_x}{l_x}$ |
| 41—42 | 77,401 | 88 | 114.19 | 9.21 | 4.81 |
| 42—43 | 76,601 | 88 | 115.52 | 9.95 | 4.74 |
| 43—44 | 75,752 | 89 | 117.31 | 10.75 | 4.69 |
| 44—45 | 74,850 | 89 | 119.38 | 11.60 | 4.62 |
| 45—46 | 72,905 | 89 | 121.64 | 12.53 | 4.63 |
| 46—47 | 71.904 | 89 | 124.00 | 13.55 | 4.57 |
| 47—48 | 70,842 | 90 | 126.39 | 14.67 | 4.51 |
| 48—49 | 69,714 | 90 | 128.98 | 15.88 | 4.45 |
| 49—50 | 68,518 | 90 | 131.82 | 17.19 | 4.40 |
| 50—51 | 67,252 | 91 | 134.66 | 18.59 | 4.34 |
| 51—52 | 65,912 | 90 | 137.24 | 20.09 | 4.30 |
| 52—53 | 64.500 | 90 | 139.33 | 21.71 | 4.25 |
| 53—54 | 63,012 | 88 | 140.02 | 23.44 | 4.21 |
| 54—55 | 61,449 | 86 | 139.47 | 25.28 | 4.17 |
| 55—56 | 59,812 | 83 | 139.04 | 27.23 | 4.14 |
| 56—57 | 58,103 | 81 | 140.08 | 29.28 | 4.12 |
| 57—58 | 56,323 | 81 | 143.93 | 31.43 | 4.11 |
| 58—59 | 54,474 | 83 | 151.60 | 33.66 | 4.10 |
| 59—60 | 52,560 | 85 | 162.20 | 35.95 | 4.09 |
| 60—61 | 50,589 | 88 | 174.21 | 38.37 | 4.08 |
| 61—62 | 48,563 | 90 | 186.12 | 40.93 | 4.07 |
| 62—63 | 46,489 | 91 | 196.42 | 43.69 | 4.06 |
| 63—64 | 44,371 | 90 | 203.86 | 46.64 | 4.04 |
| 64—65 | 42,216 | 88 | 209.46 | 49.76 | 4.04 |
| 65—66 | 40,032 | 86 | 215.09 | 53.05 | 4.04 |
| 66—67 | 37,827 | 84 | 222.59 | 56.51 | 4.05 |
| 67—68 | 35,610 | 83 | 233.85 | 60.14 | 4.07 |
| 68—69 | 33,390 | 83 | 248.91 | 63.80 | 4.09 |
| 69—70 | 31,182 | 83 | 266.52 | 67.48 | 4.11 |
| 70—71 | 29,000 | 83 | 286.61 | 71.41 | 4.14 |
| 71—72 | 26,852 | 83 | 309.12 | 75.81 | 4.16 |
| 72—73 | 24,740 | 83 | 333.98 | 80.92 | 4.18 |
| 73—74 | 22,662 | 82 | 361.22 | 86.77 | 4.20 |
| 74—75 | 20,621 | 81 | 390.90 | 93.22 | 4.21 |
| 75—76 | 18,625 | 79 | 422.96 | 100.20 | 4.23 |
| 76—77 | 16,688 | 76 | 457.30 | 107.62 | 4.24 |
| 77—78 | 14,824 | 73 | 493.88 | 115.42 | 4.27 |
| 78—79 | 13,048 | 70 | 532.73 | 123.59 | 4.29 |
| 79—80 | 11,374 | 65 | 573.91 | 132.19 | 4.31 |
| 80—81 | 9,814 | 61 | 617.33 | 141.21 | 4.33 |
| 81—82 | 8,376 | 56 | 662.94 | 150.63 | 4.34 |

TABLE 3. EXPECTATION OF MENTAL DISEASE AMONG MALES IN NEW YORK CITY, 1930 (Continued)

| Age interval, years | Of 100,000 persons born alive | | Rate of mental disease per 100,000 | Rate of mortality per 1,000 | Expectation of mental disease |
|---|---|---|---|---|---|
| Period of lifetime between two exact ages | Number alive and sane at beginning of age interval | Number becoming mentally ill in age interval | Number becoming mentally ill during age interval among 100,000 alive and sane at beginning of age interval | Number dying in age interval per 1,000 alive at beginning of interval and remaining sane during interval | Number becoming mentally ill during remainder of life of 100 alive and sane at beginning of age interval |
| $x$ to $x+1$ | $l_x$ | $i_x$ | 100,000 $s_x$ | 1,000 $q_x$ | $t_x = \frac{\sum_{x}^{104} i_x}{l_x}$ |
| 82— 83 | 7,067 | 50 | 710.66 | 160.43 | 4.36 |
| 83— 84 | 5,891 | 45 | 760.54 | 170.92 | 4.38 |
| 84— 85 | 4,847 | 39 | 812.62 | 182.11 | 4.39 |
| 85— 86 | 3,932 | 34 | 866.84 | 193.54 | 4.43 |
| 86— 87 | 3,144 | 29 | 923.12 | 204.75 | 4.45 |
| 87— 88 | 2,477 | 24 | 981.40 | 215.28 | 4.48 |
| 88— 89 | 1,925 | 20 | 1,041.72 | 223.83 | 4.52 |
| 89— 90 | 1,479 | 16 | 1,104.13 | 230.72 | 4.53 |
| 90— 91 | 1,125 | 13 | 1,168.56 | 237.88 | 4.53 |
| 91— 92 | 847 | 10 | 1,234.93 | 247.24 | 4.49 |
| 92— 93 | 630 | 8 | 1,303.19 | 260.74 | 4.44 |
| 93— 94 | 460 | 6 | 1,373.37 | 278.83 | 4.35 |
| 94— 95 | 327 | 5 | 1,445.53 | 300.22 | 4.28 |
| 95— 96 | 225 | 3 | 1,519.59 | 324.23 | 4.00 |
| 96— 97 | 150 | 2 | 1,595.48 | 350.20 | 4.00 |
| 97— 98 | 96 | 2 | 1,673.13 | 377.44 | 4.17 |
| 98— 99 | 59 | 1 | 1,752.59 | 405.96 | 3.39 |
| 99—100 | 34 | 1 | 1,833.97 | 436.22 | 2.94 |
| 100—101 | 19 | .. | 1,917.08 | 468.19 | .... |
| 101—102 | 10 | .. | 2,001.90 | 501.90 | .... |
| 102—103 | 5 | .. | 2,088.31 | 537.32 | .... |
| 103—104 | 2 | .. | 2,176.35 | 574.23 | .... |
| 104—105 | 1 | .. | 2,266.08 | 612.65 | .... |

TABLE 4. EXPECTATION OF MENTAL DISEASE AMONG FEMALES IN NEW YORK CITY, 1930

| Age interval, years | Of 100,000 persons born alive | | Rate of mental disease per 100,000 | Rate of mortality per 1,000 | Expectation of mental disease |
|---|---|---|---|---|---|
| Period of lifetime between two exact ages | Number alive and sane at beginning of age interval | Number becoming mentally ill in age interval | Number becoming mentally ill during age interval among 100,000 alive and sane at beginning of age interval | Number dying in age interval per 1,000 alive at beginning of interval and remaining sane during interval | Number becoming mentally ill during remainder of life of 100 alive and sane at beginning of age interval |
| $x$ to $x+1$ | $l_x$ | $i_x$ | $100{,}000\ s_x$ | $1{,}000\ q_x$ | $t_x = \frac{\sum_{x}^{105} i_x}{x}$ |
| 0— 1 | 100,000 | .. | ..... | 53.72 | 5.55 |
| 1— 2 | 94,628 | .. | ..... | 9.09 | 5.87 |
| 2— 3 | 93,768 | .. | ..... | 5.18 | 5.92 |
| 3— 4 | 93,282 | .. | ..... | 3.64 | 5.95 |
| 4— 5 | 92,942 | .. | ..... | 2.90 | 5.97 |
| 5— 6 | 92,672 | .. | ..... | 2.36 | 5.99 |
| 6— 7 | 92,453 | .. | ..... | 1.93 | 6.00 |
| 7— 8 | 92,275 | .. | ..... | 1.62 | 6.02 |
| 8— 9 | 92,126 | .. | ..... | 1.39 | 6.03 |
| 9—10 | 91,998 | .. | ..... | 1.26 | 6.03 |
| 10—11 | 91,882 | .. | ..... | 1.22 | 6.04 |
| 11—12 | 91,770 | .. | ..... | 1.22 | 6.04 |
| 12—13 | 91,658 | 3 | 3.80 | 1.27 | 6.06 |
| 13—14 | 91,539 | 9 | 9.35 | 1.38 | 6.06 |
| 14—15 | 91,404 | 16 | 17.07 | 1.55 | 6.06 |
| 15—16 | 91,246 | 24 | 25.77 | 1.76 | 6.05 |
| 16—17 | 91,061 | 31 | 34.22 | 1.98 | 6.04 |
| 17—18 | 90,850 | 37 | 41.21 | 2.18 | 6.02 |
| 18—19 | 90,615 | 42 | 46.58 | 2.39 | 5.99 |
| 19—20 | 90,357 | 46 | 51.13 | 2.60 | 5.96 |
| 20—21 | 90,076 | 50 | 55.13 | 2.82 | 5.93 |
| 21—22 | 89,772 | 53 | 58.80 | 3.01 | 5.90 |
| 22—23 | 89,449 | 56 | 62.41 | 3.16 | 5.86 |
| 23—24 | 89,111 | 59 | 66.00 | 3.25 | 5.82 |
| 24—25 | 88,763 | 62 | 69.40 | 3.29 | 5.77 |
| 25—26 | 88,409 | 64 | 72.55 | 3.31 | 5.73 |
| 26—27 | 88,053 | 66 | 75.39 | 3.34 | 5.68 |
| 27—28 | 87,693 | 68 | 77.85 | 3.41 | 5.63 |
| 28—29 | 87,326 | 70 | 79.77 | 3.51 | 5.57 |
| 29—30 | 86,950 | 71 | 81.18 | 3.62 | 5.51 |
| 30—31 | 86,564 | 71 | 82.35 | 3.76 | 5.46 |
| 31—32 | 86,168 | 72 | 83.53 | 3.90 | 5.40 |
| 32—33 | 85,760 | 73 | 84.96 | 4.05 | 5.34 |
| 33—34 | 85,340 | 74 | 86.63 | 4.20 | 5.28 |
| 34—35 | 84,908 | 75 | 88.37 | 4.36 | 5.22 |
| 35—36 | 84,463 | 76 | 90.21 | 4.53 | 5.16 |
| 36—37 | 84,005 | 77 | 92.19 | 4.73 | 5.10 |
| 37—38 | 83,531 | 79 | 94.37 | 4.97 | 5.04 |
| 38—39 | 83,037 | 81 | 97.00 | 5.25 | 4.97 |
| 39—40 | 82,520 | 83 | 100.07 | 5.54 | 4.90 |
| 40—41 | 81,980 | 85 | 103.16 | 5.87 | 4.83 |

TABLE 4. EXPECTATION OF MENTAL DISEASE AMONG FEMALES IN NEW YORK CITY, 1930 (Continued)

| Age interval, years | Of 100,000 persons born alive | | Rate of mental disease per 100,000 | Rate of mortality per 1,000 | Expectation of mental disease |
|---|---|---|---|---|---|
| Period of lifetime between two exact ages | Number alive and sane at beginning of age interval | Number becoming mentally ill in age interval | Number becoming mentally ill during age interval among 100,000 alive and sane at beginning of age interval | Number dying in age interval per 1,000 alive at beginning of interval and remaining sane during interval | Number becoming mentally ill during remainder of life of 100 alive and sane at beginning of age interval |
| $x$ to $x+1$ | $l_x$ | $i_x$ | 100,000 $s_x$ | 1,000 $q_x$ | $t_x = \frac{\sum_{x}^{105} i_x}{l_x}$ |
| 41—42 | 81,414 | 86 | 105.87 | 6.28 | 4.76 |
| 42—43 | 80,817 | 87 | 107.80 | 6.77 | 4.69 |
| 43—44 | 80,183 | 87 | 108.67 | 7.36 | 4.62 |
| 44—45 | 79,506 | 86 | 108.77 | 8.04 | 4.55 |
| 45—46 | 78,781 | 85 | 108.48 | 8.79 | 4.48 |
| 46—47 | 78,004 | 84 | 108.21 | 9.58 | 4.42 |
| 47—48 | 77,174 | 84 | 108.35 | 10.39 | 4.36 |
| 48—49 | 76,289 | 83 | 108.90 | 11.16 | 4.30 |
| 49—50 | 75,356 | 83 | 109.60 | 11.92 | 4.24 |
| 50—51 | 74,376 | 82 | 110.46 | 12.73 | 4.19 |
| 51—52 | 73,348 | 82 | 111.46 | 13.68 | 4.13 |
| 52—53 | 72,264 | 81 | 112.63 | 14.82 | 4.08 |
| 53—54 | 71,113 | 81 | 113.81 | 16.17 | 4.03 |
| 54—55 | 69,883 | 80 | 115.00 | 17.68 | 3.99 |
| 55—56 | 68,569 | 80 | 116.42 | 19.34 | 3.94 |
| 56—57 | 67,164 | 79 | 118.30 | 21.13 | 3.91 |
| 57—58 | 65,667 | 79 | 120.87 | 23.05 | 3.88 |
| 58—59 | 64,076 | 79 | 123.89 | 25.11 | 3.85 |
| 59—60 | 62,390 | 79 | 127.30 | 27.31 | 3.83 |
| 60—61 | 60,609 | 80 | 131.32 | 29.64 | 3.81 |
| 61—62 | 59,735 | 81 | 136.15 | 32.09 | 3.73 |
| 62—63 | 57,740 | 82 | 142.50 | 34.62 | 3.72 |
| 63—64 | 55,662 | 83 | 149.20 | 37.17 | 3.72 |
| 64—65 | 53.513 | 84 | 156.49 | 39.74 | 3.71 |
| 65—66 | 51,306 | 85 | 164.81 | 42.45 | 3.71 |
| 66—67 | 49,047 | 86 | 174.57 | 45.44 | 3.70 |
| 67—68 | 46,736 | 87 | 186.18 | 48.83 | 3.70 |
| 68—69 | 44,371 | 88 | 199.24 | 52.55 | 3.70 |
| 69—70 | 41,956 | 90 | 213.45 | 56.52 | 3.71 |
| 70—71 | 39,500 | 91 | 229.46 | 60.85 | 3.71 |
| 71—72 | 37.011 | 92 | 247.89 | 65.61 | 3.71 |
| 72—73 | 34,497 | 93 | 269.36 | 70.92 | 3.72 |
| 73—74 | 31,964 | 95 | 295.98 | 76.92 | 3.72 |
| 74—75 | 29,418 | 96 | 327.31 | 83.53 | 3.72 |
| 75—76 | 26,873 | 97 | 360.23 | 90.55 | 3.71 |
| 76—77 | 24,351 | 95 | 391.61 | 97.77 | 3.70 |
| 77—78 | 21,884 | 92 | 418.31 | 104.98 | 3.68 |
| 78—79 | 19,504 | 85 | 436.54 | 112.02 | 3.66 |
| 79—80 | 17,244 | 78 | 448.36 | 119.03 | 3.64 |
| 80—81 | 15,123 | 69 | 459.51 | 126.26 | 3.64 |
| 81—82 | 13,153 | 63 | 475.70 | 133.93 | 3.66 |

TABLE 4. EXPECTATION OF MENTAL DISEASE AMONG FEMALES IN NEW YORK CITY, 1930 (Continued)

| Age interval, years | Of 100,000 persons born alive | | Rate of mental disease per 100,000 | Rate of mortality per 1,000 | Expectation of mental disease |
|---|---|---|---|---|---|
| Period of lifetime between two exact ages | Number alive and sane at beginning of age interval | Number becoming mentally ill in age interval | Number becoming mentally ill during age interval among 100,000 alive and sane at beginning of age interval | Number dying in age interval per 1,000 alive at beginning of interval and remaining sane during interval | Number becoming mentally ill during remainder of life of 100 alive and sane at beginning of age interval |
| $x$ to $x+1$ | $l_x$ | $i_x$ | 100,000 $^{s}{}_{x}$ | 1,000 $q_x$ | $t_x = \frac{\sum_{x}^{105} i_x}{l_x}$ |
| 82— 83 | 11,337 | 57 | 502.66 | 142.29 | 3.70 |
| 83— 84 | 9,675 | 52 | 542.59 | 151.55 | 3.74 |
| 84— 85 | 8,165 | 48 | 591.69 | 161.57 | 3.80 |
| 85— 86 | 6,806 | 44 | 646.64 | 172.00 | 3.84 |
| 86— 87 | 5,599 | 39 | 704.11 | 182.53 | 3.89 |
| 87— 88 | 4,545 | 35 | 760.77 | 192.84 | 3.94 |
| 88— 89 | 3,640 | 30 | 818.84 | 201.62 | 3.96 |
| 89— 90 | 2,882 | 25 | 880.53 | 209.10 | 3.96 |
| 90— 91 | 2,260 | 21 | 942.53 | 217.22 | 3.94 |
| 91— 92 | 1,753 | 18 | 1,001.51 | 227.92 | 3.88 |
| 92— 93 | 1,340 | 14 | 1,054.16 | 243.15 | 3.73 |
| 93— 94 | 1,004 | 11 | 1,096.50 | 263.68 | 3.59 |
| 94— 95 | 731 | 8 | 1,130.74 | 288.22 | 3.42 |
| 95— 96 | 515 | 6 | 1,162.84 | 315.60 | 3.30 |
| 96— 97 | 348 | 4 | 1,198.71 | 344.68 | 3.16 |
| 97— 98 | 225 | 3 | 1,244.57 | 374.29 | 3.11 |
| 98— 99 | 139 | 2 | 1,302.39 | 404.26 | 2.88 |
| 99—100 | 82 | 1 | 1,368.27 | 435.35 | 2.44 |
| 100—101 | 46 | 1 | 1,438.88 | 467.84 | 2.17 |
| 101—102 | 24 | .. | 1,510.90 | 502.02 | .... |
| 102—103 | 12 | .. | 1,581.01 | 538.17 | .... |
| 103—104 | 6 | .. | ..... | 576.27 | .... |
| 104—105 | 3 | .. | ..... | 616.15 | .... |
| 105—106 | 1 | .. | ..... | 657.81 | .... |

# WILLIAM ALANSON WHITE

JOURNEY'S END has come to Dr. William A. White of Washington, D. C., who died, Sunday, March 7, 1937, at the age of sixty-seven. His body rests in the Rock Creek Park Cemetery, but the spirit that infused it and made him the man he was, a leader among us, will continue its influence in ever-widening circles. Mental hygiene has lost an actual person, dear to all, but it can never lose what he has done for the movement.

From simple beginnings he rose to supreme heights of accomplishment, respected, admired, and endeared to all. He has himself written an outline of his life work in the realm of psychiatry in a delightful autobiographical sketch, *Forty Years of Psychiatry,* from which the bare scaffolding of a life rich in service may be gathered. Born in Brooklyn, January 27, 1870, of parents in modest circumstances, it would seem that he was conditioned early to medicine, for as this autobiography notes, he lived on the same block as the Long Island Medical College Hospital, and the clang of the ambulance bell was among his earliest associations. He was in and out of the hospital through his boyhood, as his chums were sons or nephews of the medical staff. After going through the public school, he obtained a competitive scholarship at Cornell University and for four years lived and worked as an optional student to the age of nineteen, when he entered the medical school of his boyhood neighborhood.

At Cornell his interests were strongly along natural-history lines. He added to a bare purse by extra work in the laboratories and museums and thus came into more intimate contact both with his teachers and with the subject matter of science than many of his classmates. Here was begun the habit of systematized and orderly occupation that characterized his later career; also that faculty of getting quickly into the core of things which made him such a successful teacher, administrator, and propagandist.

Graduating in medicine at the age of twenty-one, after short interneships in New York he obtained a fourth interne-

ship at Binghamton State Hospital, then under the ægis of a young and enterprising psychiatrist, Charles G. Wagner. Here he worked hard and, as he writes, played hard, but laid the basis of a solid foundation in psychiatry. By 1903 his merits were sufficiently outstanding to cause President Theodore Roosevelt to appoint him Superintendent of St. Elizabeths Hospital in Washington. This position of eminence he made preëminent by an extraordinary diligence, a high type of administration, and an alert and sympathetic intelligence, so that during the thirty-four years of his superintendency, St. Elizabeths Hospital came to represent the acme of humanitarian service for the mentally ill.

Early in his career Dr. White sought for a deeper understanding of his fellow men than that offered by the psychologies of the schools and the then prevailing psychiatric conceptions. He became aware of the great significance of the unconscious, first through his studies in hypnoidal phenomena at the newly founded State Pathological Institute and later in his following up of the work of Freud and the psychoanalytic school.

No one has been more influential in the United States than he in the spread of the psychoanalytic conceptions. His masterly *Outlines of Psychiatry* has done more to train students in psychiatry than any work of recent years. From 1907 to 1936 it has appeared in fourteen revised editions. In 1913 he and I together founded *The Psychoanalytic Review*, and shortly thereafter started the Nervous and Mental Disease Monograph Series, which now includes some sixty volumes on subjects of neurology and psychiatry, psychoanalysis, and mental hygiene.

His interest in and active propaganda for mental hygiene began early after his settling in Washington, and for many years he has served on important committees of The National Committee for Mental Hygiene. His many lectures and books did yeoman's service in the advance and success of this movement. In 1930 he was President of the International Committee for Mental Hygiene and President of the First International Congress on Mental Hygiene which was held in Washington and to the great success of which he contributed in large part.

We will not enumerate here the many positions of honor

and trust that he occupied and adorned. No effort in the United States that looked forward to betterment of the humanities in the psychiatric field but received his hearty and efficient support. As a speaker he was simple, direct, and forceful. As a writer he was prolific, direct, entertaining, and enlightening. He was a Thomas Huxley to the Darwins of psychiatric science. He was a sound interpreter and a steadfast exponent of the best psychiatric research.

As a man he was universally liked and respected. His judgment was widely sought and he had an unusually large circle of steadfast and sturdy friends. He was determined, yet not impulsive, and above all he had an all-comprehending humor that made him adequate to the most intricate and involved situations in daily life.

His was a rare personality and his like will be hard to find.

SMITH ELY JELLIFFE.

## BOOK REVIEWS

PRISONS AND BEYOND. By Sanford Bates. New York: The Macmillan Company, 1936. 308 p.

The author of this volume, who until his resignation early this year was Director of the Federal Bureau of Prisons, gives here a brief historical sketch of the use of prisons, discusses the pressing problems involved in prison development and administration, describes the federal system recently instituted, and lays before the reader the fundamental questions affecting this part of our structure of law and order. The style is easy, almost chatty, and it rings with the sort of homely authority that comes only from the man who has lived intimately with his problem.

At every point the reader may draw his own conclusions. Mr. Bates candidly sets out both sides of the question and does not flinch from acknowledging mutually antagonistic rights and claims. His discussions of the various problems involved in prison labor and of the apparently antagonistic demands of individual reform as opposed to "safe-keeping" are especially good. He rather skillfully jockeys the reader into the position of realizing for himself that there must be certain very disturbing paradoxes in the prison structure.

The subject is important because there emerge from our prisons or jails about 1,000,000 persons each year. While the book deals chiefly with the federal system, with a population of about 16,000 prisoners, it frequently touches upon the larger field and indicates certainly that the policies of the federal government will slowly find their way even to the county and municipal units.

For the social worker or the layman who desires an authoritative statement of the problems involved in the construction of a system that will really re-form prisoners, this is a necessary book—even if he concludes that the hazards in the path of such a goal are well-nigh insurmountable. To such a person we commend also Mr. Bates's dispassionate and fair assay of the problems of probation and parole. On the other hand, the student of mental mechanisms will find little here that is new or challenging. Mr. Bates rather signally fails to point out that the prison culture is a culture of failure, that most of its individuals have been pawed over by every sort of social agency before this last resort is tried—and he tells us little of what the prisoner does when faced with the dismal recognition that what he has been threatened with for years has now overtaken him.

For the social engineer with any sort of administrative responsibility, the book is a well-packed fund of necessary knowledge. For the case-worker, the reviewer finds little of importance. These criticisms are made from a technical point of view, since any one must be thrilled by this story of the building of an honest, humane, constructive system of handling the offender.

The problems of the prison seem so overwhelming and their solution seems to involve such difficulties that it is surprising the author does not lay more stress upon the need of true prevention in the field of those earlier areas of juvenile problems which seem so inevitably to lead to the final common pathway of crime. The reviewer is fully aware of the present inadequacies of this earlier attack. Yet the alternative that this book presents is so full of knotty and, in places, insoluble difficulties that we *must* set our faces toward the goal of prevention. This does not mean probation—that's too late. This does not mean the juvenile court—that's too late. It has something to do with better housing, with the chance to play, with a more realistic school program, with the right to swing one's arms or throw a stone without breaking the law, and with a nation of adults who in honesty and fair dealing show in their own lives a pattern which the child may safely follow.

JAMES S. PLANT.

*Essex County Juvenile Clinic, Newark, N. J.*

SUPERVISION IN SOCIAL CASE-WORK. By Virginia P. Robinson. Chapel Hill, N. C.: University of North Carolina Press, 1936. 199 p.

This book makes a significant contribution to the profession of social case-work. In this profession the supervision of workers, emerging as it did in the midst of case-work practice, was for a long time confused with it. Many supervisors, themselves ex-case-workers, when supervising case-workers were prone to think of the task as an extension of case-work service and to bring habitual attitudes and methods to it. For some years, however, there has been a growing realization that an educational process is involved here, and at this stage of first awareness the members of the profession have begun to think about supervision and to discuss it. The meager biblography on this subject indicates that not a great deal of the thinking has been formulated. It suggests also that perhaps too little thinking has been done in this field. While a few writers have established the point that supervision is an educational process, Miss Robinson goes further in describing that process and in clarifying its difference from case-work, even though it is indigenous to case-work.

In the first section the author presents, in accordance with the con-

cepts of Otto Rank, a descriptive definition of the learning process in its organic and functional aspects. Yet beneath the surface one perceives basic growth principles inherent in the learning process which should be useful to any educator, regardless of his particular analytical persuasion. This phase of the book makes a contribution not only to content of knowledge, but also in the fact that it signals the need that the case-work supervisor be oriented in fields other than her own. Being an educator, she should have this kind of deep understanding of learning processes and a grasp of the basic educational principles that emerge from such an orientation, even though the concepts that she eventually accepts may not be identical with those employed here.

In Part II Miss Robinson focuses upon the learning process as it takes place in the supervisory situation. She first defines the limits of the process, a sound step in the orientation of any supervisor, for too often supervisors unaware of limitations have been confused in their purposes, baffled at their own ineptitude, and frustrated in the realization of adequacy as educators, with a resultant destructive effect upon the student workers. The author is explicit in defining the responsibility of the supervisor, and in this connection clearly distinguishes education from therapy. For some time it has been recognized that the supervisor should not assume therapeutic responsibility for the student. Other writings have emphasized this significant point and have stressed the importance of focusing upon the case-work production, taking up the student's problems only in so far as they have been manifested in the case-work situation. And yet it was not clear to many persons just how to avoid involving the total personality in such a way as to precipitate a therapeutic situation. Miss Robinson clarifies this step by step in her differentiation of the personal and the professional selves, and deals with the latter so explicitly as to give the reader a real feeling of how the professional self of the individual can be kept in focus.

Other noteworthy material in Part II is that in the chapters *The Student's Utilization of the Learning Experience* and *The Development of Supervisory Capacity*. Again, throughout Part II, the author conveys more than a certain content of knowledge relevant to the profession. Her very conception of the supervisory situation implies the need that the case-work supervisor have a mature orientation if she is to contribute to the professional development of the worker.

This book offers a rich philosophy of education and a deep understanding of human behavior. It may be criticized through being identified with a particular psychology by those engrossed in its superficial aspects. But it surpasses the confines of a school through

penetrating to fundamental principles. It is a volume that demands rereading—in fact, one that case-work supervisors will find a continuing source of reorientation and stimulation. Furthermore, it opens up wide areas the development of which the limitations of the author's purpose forbade, but which will provoke the thoughtful reader into critical exploration. CHARLOTTE TOWLE.

*Graduate School of Social Service Administration,*
*University of Chicago.*

THE FUTURE OF MARRIAGE IN WESTERN CIVILIZATION. By Edward Westermarck. New York: The Macmillan Company, 1936. 281 p.

No writer on marriage is entitled to more consideration than Edward Westermarck. Despite the enormous literature dealing with sex and marriage, his three volumes on the history of human marriage remain an outstanding monument of scholarly investigation.

History deals with the past, but in this instance the historian forsakes the safety of the past and seeks to penetrate the future. Whether dealing with the past or the future, Dr. Westermarck makes a sociological approach, in terms of probable causes. He presents his investigations concerning the various forms of marriage as they exist the world over, and attempts to analyze the factors that enter into their present status, with a view to determining the probabilities that marriage will survive as an institution.

He has carefully considered the essential elements in marriage, the causes of matrimonial unhappiness, including sexual maladjustment, adultery, and jealousy. With clarity and frankness, he discusses the various forms of temporary marriage, concubinage, and free love, and then analyzes the problems of monogamy and polygamy, divorce, and certain factors that enter into the relationship between sexual behavior and morality. With his usual adequate documentation and careful analysis of the broad implications of the subject matter, he finally arrives at a reasonable prediction of the survival of marriage and the family.

Throughout the volume he recognizes marriage as an institution based upon certain primary feelings which still continue to operate in human affairs. He does not moralize, but with great objectivity urges that sexual acts are morally indifferent and are not proper subjects for penal legislation if nobody is injured by them. He arrives at this opinion after considering the essential nature of the emotions that enter into sexual acts.

The breadth of his point of view is well represented by his recognition that "mere antipathies are not sufficient ground for interfering

with other individuals' liberty of action, either by punishing them or subjecting them to moral censure." This is an ethical concept that possesses a wide mental-hygiene connotation.

In brief, Dr. Westermarck holds that marriage and the family are dependent upon conjugal and parental sentiments, and, so long as these continue, marriage and the family will also. In other words, all basic social institutions depend upon a continuing form of behavior grounded in the emotional sphere. They are not matters of logic and reason, but of the organization of emotional life for its own guidance, in terms of its own satisfactions. Morality and utilitarianism are less important than the acceptance or avoidance of a large variety of sexual relationships.

Despite varying interpretations of marriage, Westermarck regards it, in its conventional sense, as "the name for a social institution sanctioned by custom or law." Based upon deep biological foundations, marriage became crystallized into a primeval habit which, through custom and law, became organized into a social institution. The basic factors that make the prophesy of its survival reasonable consist of the three elements essential to every normal marriage: "The gratification of the sexual impulse, the relationship between husband and wife apart from it, and procreation." Inherent in these three motivations of marriage are the sources of happiness and unhappiness.

Unfortunately it is the unhappy marriages that give rise to most of the discussions, which proclaim the bankruptcy of marriage and the disintegration of the family. Yet the recent experience of Russia indicates that, with the most liberal concepts of sexual relationships, there seems to be a vital reason for tightening the bonds of matrimony, enhancing family relationships, and establishing marriage and the family as the basis of national organization. Marriage remains an accepted and highly valued social institution, providing a happiness and efficiency transcending that derived from mating without social responsibility.

This book merits a wide reading by all who are concerned with sex and mental hygiene, mating and marriage, efficiency and happiness, personal adaptation and social adjustment.

IRA S. WILE.

*New York City.*

PREPARATION FOR MARRIAGE. By Ernest R. Groves. New York: Greenberg, Publisher, 1936. 124 p.

On every hand one hears these days some gospel of preparedness. Front-page headlines blazon national preparedness; economists and

sociologists propound theories on preparedness for, or before, the next depression; schools and employers ever urge better and more specialized preparedness for jobs; and from pulpits still "the voice in the wilderness" arises, crying, "Prepare ye! Prepare ye!"

Yet, in spite of all this writing on the wall, how surprisingly little is available to the layman that is truly practical, as well as scientifically true, when it comes to preparedness for what is one of the most real and dynamic of experiences, common to the large majority of human beings—namely, marriage.

It is, therefore, with much eagerness that one turns the pages of such a book as *Preparation for Marriage,* by the well known sociologist, Professor Ernest R. Groves, for "young people who *realize* how much they need to prepare for marriage, not because they are fearing failure, but that they may avoid every needless difficulty and win every possible satisfaction."

Here, at the very outset, I take issue with the author, for as I read, the thing that impresses me is what a telling argument the small volume is in the cause of preparedness for marriage and how thought-provoking and convincing for those who *do not realize* the need for preparation. There is no page that is not readable and understandable throughout, for the book is written in simple, friendly language, presenting the various aspects of marriage with a wholesome, outspoken seriousness, which, however, at no point stirs up overconcern or disgust.

Outstanding among its good points is the apportioning of the last ten pages in Chapter 1 to the subject of "sharing confidences"— a topic much too frequently overlooked, which, as the writer says, "simple as it seems, may bring about unnecessary difficulties, occasionally leading to estrangement or a suspicion that appears later in marriage." Professor Groves covers with gratifying thoroughness "what of the past should be discussed in preparation of marriage and why." According to him, the question, "Is it what one wants to tell or what the other needs to know?" should be the criterion as to whether "the spoken confidence is a confession (prompted by selfishness and weakness) or the giving of information (indicative of loyalty and justice) which would make married life easier and richer." With clarity and expertness, he has condensed a good deal of scientific knowledge into a few brief pages of common sense.

One cannot but commend also his handling of problems of health and heredity in Chapter 2, as well as the adequacy and frankness, in no way offensive to any one's sensibilities, with which in chapters 4 and 5 he discusses pre-marital examination, its meaning, value, and content.

It is all the more surprising, therefore, that after such thoroughness and specificity in these first chapters, the author should resort to the veritable "catch-all" method of disseminating knowledge that one finds in the last chapter, *Building the Domestic Program*, into which odd bits of information on "the wedding," "budget-making," "religion," "legal qualification," and sundry other left-overs have been thrown. Sixteen topics are commented upon in about as many pages, leaving one rather breathless and dissatisfied after the painstaking care and detail shown by the author elsewhere. One wishes Mr. Groves had not so casually dismissed such pertinent topics as "Religious Understanding," "If the Woman Works," and other equally vital themes which in this day and age seem to warrant more than the few lines here accorded them.

The most surprising thing, however, is the fact that the author of *Understanding Yourself* gives practically no place in his present book to the need for better knowledge of one's self and why one feels and acts as one does. In several instances, Professor Groves hints at the importance of personality, but that is as far as he goes. He says: "Marriage is a fellowship; it is not a loss of identity . . . the husband and wife start as separate personalities . . . they cannot become one person." And again, in his volume entitled *Wholesome Marriage*, he points out that "each member of the marriage partnership has to bring his personality . . . into the coöperative enterprise. Neither can shake off the accumulation of past experiences nor is this necessary."

The book seems incomplete without some orientation on the subject of personality, for I feel with Dr. M. F. Nimkoff that "a great many marriage and pre-marriage problems turn out on analysis to be primarily personality problems." It is, therefore, vital to any discussion of marriage that some thought be definitely focused on the need of a better understanding and acceptance of one's own self and that of the chosen mate.

The book itself ends with another hint on the topic of personality with the challenge: "Marriage is a maturing experience. Husband and wife do not stumble into happiness. They build it. In the process they also build maturity and integrity, the supreme virtues of a thoroughly modern man and woman."

These criticisms notwithstanding, *Preparation for Marriage* deserves a place on the library shelf of any person contemplating matrimony, and the chapters first discussed are alone worth the price of the book.

ESTHER M. DIMCHEVSKY.

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CURRICULUM GUIDES FOR TEACHERS OF CHILDREN FROM TWO TO SIX YEARS OF AGE. By Ruth Andrus and Associates. New York: John Day in association with Reynal and Hitchcock, 1936. 299 p.

The general nature and purpose of this book is indicated by the title. It includes, as one would expect, suggested programs for nursery school and kindergarten, lists of equipment, picture books, music and poetry suitable for young children, and a list of general reference books on the care and training of children under the age of six.

The main body of the book is taken up with a long series of presumably verbatim records of typical nursery-school and kindergarten episodes, involving various types of activity by children of different ages. Each episode is analyzed to show the conditions that led up to it, its significance for the children who participated in it, and why the teacher handled the situation as she did; or, in some instances, a different and possibly better method of dealing with it is suggested. The scheme is an ingenious one, with definite possibilities for teacher-training, but the two hundred and more pages that are here given up to the bald recounting of one commonplace event after another, with all the nonessentials left in, become extremely wearisome to read. The use of the formal outline in analyzing the records seems unnecessarily pedantic, and greatly increases the length of the discussions. In most cases, two or three pithy sentences would have brought out the essential points more closely than is done by two or three pages in semi-tabular form.

This part of the book closes with an eight-page chapter on home-school relationships, which seems like an extremely small amount of space to devote to so important an aspect of modern nursery-school education, especially when it is noted that four of the eight pages are given up to an itemized account of a parent's first visit to a nursery school, where, among other things, she assists some of the children in taking off their wraps. The meticulosity with which the smallest details have been set down—*e.g.*, such important events as "Parent pulled down each sleeve of D's suit," "Parent pulled down suit," "Parent zipped zipper on one legging," on to the final triumph when, after turning, looking, and putting hand into locker, the child eventually succeeds in depositing cap, mittens, rubbers, and snow suit in their appointed places within the locker—reflects great zeal on the part of the recorder, but is a bit suggestive of William James's famous remark about the counting of rocks on a New England farm. Science does more than record facts; it selects facts and organizes them into a coherent pattern.

The authors have done an excellent job in showing how the seemingly trivial events of everyday experience are the very warp and

woof from which personality is built up. Education consists largely in the knitting together of little things. Yet there are many events occurring within and about us that form no intrinsic part of the life pattern, so far, at least, as we are able to see it. They occur, they pass, and seem to be forgotten. Granted that in not a few instances the seemingly trivial may prove itself to have been in fact the most significant part of the entire situation, I still question the likelihood that a reader, unacquainted with the individual children, and with only the very incomplete picture provided by the written account, will be able to see that which was hidden from the original observer. For however detailed and discursive such an account may seem to be, much is inevitably left out.

I think, therefore, that the book would better serve its purpose as a guide to the inexperienced teacher if the records were cut to their minimal essentials, with most of the irrelevant details omitted, and if the discussions that follow each episode were made less formal in style. If this were done, the space saved might be devoted to a more adequate consideration of fundamental principles that would lead the student to a clearer realization of the goals toward which he is working, and to a more comprehensive analysis of the basic relationships between the school and the home.

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EDUCATION FOR ADJUSTMENT; THE CLASSROOM APPLICATIONS OF MENTAL HYGIENE. By Harry N. Rivlin. New York: D. Appleton-Century Company, 1936. 419 p.

Literature dealing with mental-hygiene principles as they contribute to an understanding of the developing personality of the child has long been available to classroom teachers. *Educating for Adjustment* is a pioneer effort to assemble in one volume some criteria of emotional stability desired for all children; theoretical explanations of behavior that deviates from the norm as advanced by various psychological, psychiatric, and psychoanalytic schools; consideration of the influence on child personality of such factors as mental deviations, physical difficulties, sex conflicts, and undesirable home and other environmental conditions; and — what has *not* been available in any comprehensive form — a practical and helpful application of mental-hygiene principles to procedures in teaching, discipline, and general classroom management.

The value of the book is enhanced by its careful organization and by the lucid and readable style. Illustrative material is drawn freely from actual classroom situations. Stress is placed on what the class-

room teacher can do, not only to correct personality deviations and prevent their occurrence, but to develop healthy personalities in all school children.

Dr. Rivlin's opening sentence is an arresting one: "Mental hygiene in the classroom is an unfortunate expression if it suggests the picture of a teacher engaged in a dramatic struggle to keep her children from going insane." His philosophy is well expressed in a succeeding paragraph: "It [mental hygiene] is rather an attitude and a point of view that should influence everything the teacher does professionally: her method of asking questions as well as her manner when accepting answers; the procedure followed in administering tests and that governing her supervision of playground activities; the appeals by which she stimulates the pupil's desire to participate in classroom activities and the measures to which she resorts to bring the unruly into line; her attitude toward the asocial child, such as the young thief or the bully, and that toward the unsocial pupil whose timidity prevents him from mingling with others. Far from being a distinct group of skills and facts, mental hygiene in the classroom takes on significance only when it is bound up so inextricably with all the teacher does that careful analysis alone can reveal its exact influence."

Dr. Rivlin emphasizes the need for understanding behavior in the light of the child's total personality and the environmental situation in which he is placed. Each chapter is followed by questions for discussion and by an extensive bibliography. The whole is carefully indexed. In addition to providing helpful reading for supervisors and teachers, *Educating for Adjustment* could be used profitably as a basis for teacher discussion groups.

One regrets that Dr. Rivlin's oversimplification of the tenets of certain of the psychoanalytic schools has resulted in a distortion of these tenets, thus contributing to the prejudices which all too frequently abound in lay groups. One regrets, too, that while he so wisely suggests that teachers refrain from encroaching on the field of the psychiatrist and cites instances which indicate a need for reference to a psychiatrist rather than for treatment by the teacher, he does not point out the equal inadvisability of the classroom teacher's encroaching on the field of the social case-worker or visiting teacher. He encourages teachers to prepare social histories which might lead them into areas fraught with difficulty to one untrained in case-work practice. Teachers are further encouraged to read records of social agencies dealing with the families of children in their classrooms — records that would be available only to social case-workers. That classroom teachers should be interested in and sensitive to children's needs for healthy growth, and that classroom procedures should be

modified to insure that growth, is beyond question. Teachers will be greatly helped in this direction by Dr. Rivlin's book. Should this interest, however, take the teacher outside of the school into areas where she is not equipped to function, it might not only be embarrassing for her, but carry serious potential dangers for the child and his family. Is not the need, rather, for the development of departments of visiting teachers — psychiatric social case-workers — that the classroom teacher's contribution to the healthy personality development of *all* children may be supplemented by a knowledge of the needs of individual children as revealed to the case-worker, and that treatment of individual problems may be met adequately by those trained to deal with them?

Again, Dr. Rivlin's sanction of the school's occasional corporal punishment of adolescent children and of demotion to a lower grade as a disciplinary measure for misconduct is at strange variance with the very real understanding of children and their emotional needs so apparent throughout his book.

But of the book as a whole one can say that it is a scholarly compilation of material which evidences not only wide reading, but broad experiences and which should have value for teachers everywhere.

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PERSONALITY MALADJUSTMENTS AND MENTAL HYGIENE: A TEXTBOOK FOR PSYCHOLOGISTS, EDUCATORS, AND MENTAL-HYGIENE WORKERS. By J. E. Wallace Wallin. New York: McGraw-Hill Book Company, 1935. 511 p.

This book is based upon first-hand investigation of a large number of cases of mental defects, disabilities, and adjustment difficulties, as well as the information already available in technical literature. It begins with a positive treatment of the concept of mental health and the wholesome personality, indicates the types of child with which mental hygiene is concerned, and proceeds to a discussion of symptoms of maladjustment. Faulty mechanisms are widely illustrated by case studies and autobiographical material, and positive suggestions for thoroughgoing preventive programs are presented.

It is a difficult book to review, because of the large amount of case illustration included, and because of its wide scope. The general emphasis throughout is on difficulties of adjustment, shown in many ways, and on the underlying mechanisms, knowledge of which will indicate the most fruitful lines of correction and therapy. In consequence of this, the treatment of a truly positive conception of mental

health and development suffers somewhat. While the case illustrations are concrete and admirably chosen, the interpretation is speculative and clinical, rather than systematic and rigidly scientific. This is to some degree inevitable at the present stage of progress in this field, but a clearer definition of the nature of development, with less emphasis on the many deviations, would undoubtedly have pointed the way to a more objective outlook. Approaching the subject from the angle of the maladjusted, the book undoubtedly shows a tendency toward subjectivism, even though the author is eclectic rather than subservient to a single point of view.

The entire book is very interesting and full of worth-while material, reflecting wide experience in the practical field and familiarity with the literature.

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The Return to Religion. By Henry C. Link. New York: The Macmillan Company, 1936. 181 p.

In the last few years a good deal has been said about the impossibility of reconciling certain psychological tenets with religion. Much interest was aroused, therefore, when a book appeared by a well-known expert in applied psychology, with the above title. The volume bids fair to become a best seller in theological circles, probably because of the surprise aroused in the minds of the clergy that any one in this particular field should declare so frankly his adherence to the Faith of his Fathers.

But a careful reading fails to discover for this reviewer anything about religion. There is a good deal about religious observances and the upholding of certain moral principles. These observances and principles have suggested to the author various formulæ for personal counseling and suggestions for therapy, which formulæ and suggestions have to do with all the phases of life in a community — being educated, going to church, finding a vocation, amusing one's self, seeking a mate, and so on. These are all of them large subjects; they are necessarily treated very briefly and with a positiveness, even a tendency toward fascism, which may easily arose questioning rather than agreement in the reader.

But to put on one side strictures on the book itself, some of which are provoked by the choice of a title, certain of the points made by the author fill great gaps in much of the psychological therapy carried on to-day. Unfortunately, these points often seem more valuable than the reasons given for making them. Take, for instance, doing things when you don't want to — even, the author insists, *because* you do not want to. Every one must often go against his inclinations;

it is the part of a good sport to do so graciously and with poise, and it is an important part of the social education of children to learn that they cannot always have their own way. Many so-called "nervous invalids" show their illness most in their insistence on being given in to. Undoubtedly many people on the edge of such an illness would be greatly benefited by an effort to adapt their desires to the needs or convenience of others. But to insist that the value lies in going against one's inclinations rather than in what is accomplished by so doing seems an emphasis in the wrong place. Why give so much importance to wanting and not wanting, liking and not liking? There are other values which enter into the situation which it is far more important to emphasize and which are more truly attributes of the religious person than mere self-denial. Every one knows the boys and girls in secondary school whose marks rise and fall according to whether they like or dislike a teacher. One would not say to such children, "Do the work well because you dislike the teacher." Surely the aim should be rather to minimize the importance of liking or disliking and to emphasize goals and values — for instance, independence, worth-while ambition, consideration for and active interest in others. This does not seem a counsel of perfection. Such emphases can be made dynamic and suited to the young or the maladjusted individual's power to assimilate them. The author's statement is true so far as it goes; "No discovery of modern psychology is, in my opinion, so important as its scientific proof of the necessity of self-sacrifice or discipline to self-realization and happiness. By nature the individual is selfish and inclined to follow his immediate impulses . . . this road leads to introversion, to emotional instability and neurotism, to intellectual futility, to maladjustment, to unhappiness. It requires religion, or something higher than the individual or even a society of individuals, to overcome the selfish impulses of the natural man and to lead him to a more successful and fuller life." This may be enough for psychological therapy. It does not seem to the reviewer to express very adequately the spirit of religion, which must go on to positive loyalties rather than be content with negative renunciations.

In the use of the terms *introversion* and *extraversion* the author differs from the customary psychological usage. He seems to mean by these terms what Overstreet has so vividly described in his book, *About Ourselves,* as *expansive* and *contractive* personalities. In *The Return to Religion,* introversion is made synonymous with selfishness, extraversion with an unselfish and outgoing nature. But there are certainly extraverted people who are so intent on activity for its own sake that they fail in sensitiveness to the needs and feelings of others. Also, they never have time to give to the acquisition of a philosophy

for their own living. Time must be spent in doing rather than in reflection. The selfish extravert is a difficult individual to counsel; he is too content with his own methods; he does not easily gain insight into his extreme maladjustment to his social environment.

But evidently the purpose of the author, however much one may differ with his terminology, is to make clear another failing in much of present-day psychotherapy. Too often the patient or client is led through a long process of introspection without any encouragement toward healthful activity. Therapy so often is promoted by a piece of work satisfactorily accomplished that counseling, more frequently than it seems to do, should include the search for such activity — even for a time substitute it for more subjective analysis. No one can dispute the author's contention that selfishness is wholly unhealthy; there should be a way, without resorting to moralizing, to make this clear and acceptable to the client.

In the last chapter, *The Abundant Life,* there is reference to a deeper philosophy than many counselors seem to possess. Undoubtedly there would be more frequent successes in the process of dealing with distressed personalities if something beyond the understanding of his difficulties could be given the client. First one understands; then one should go on to organize, not only plans for action, but plans for thinking in a way that shall be effective in bringing about "the more abundant life."

In his discussion of the best methods of promoting mental hygiene the author quotes many of the words of Jesus as found in the New Testament, among them: "I am come that they might have life and that they might have it more abundantly"; "Take heed and beware of covetousness; for a man's life consisteth not in the abundance of the things which he possesseth"; "But seek ye the Kingdom of God and His righteousness and all these things shall be added unto you." And he gives point and emphasis to all that has gone before when he says (p. 168): "The abundant life, psychology proves, can never be defined in terms of money. It can only be defined in terms of habits, that is character. Happiness never resides in what an individual has, but always in what the individual does. It never consists of what an individual receives, be it much or little, but always of what he gives, not in money, but of himself." And if he would add that it also consists in the strength and sincerity of his inner life, his attitudes and loyalties, he would not necessarily subtract from the psychological validity of the discussion; he would, on the other hand, come nearer to justifying his use of the term "religion" and greatly enrich its content.

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WHY I THINK SO; THE AUTOBIOGRAPHY OF AN HYPOTHESIS. By Ethel S. Dummer. Chicago: Clarke-McElroy Publishing Company, 1936. 274 p.

This small privately printed book is an expression of much of the author's thought life. As those who have followed the mental-hygiene movement know, many interested laymen were caught up in the current of its activities and contributed either of their time or of their means or both to certain of its widespread developments. Among these was Mrs. Dummer, a woman of intelligence and energy, who early in her career came under the influence of certain educational ideas which emanated from the Booles, George and Mary, who in 1855 wrote a more or less Herbartian work on the "laws of thought." These ideas were of the earlier Darwinian-Mach-Hering type and have endured in essence to the present day, speaking very generally.

With this background, and the stimulating influence of a highly educated and intelligent husband, Mrs. Dummer has been active for some decades, coming in contact with most of the workers in psychiatry and the social sciences, and utilizing her wealth freely in helping to spread useful doctrines. She has sponsored research, encouraged lecturers, stimulated young educators. It would be wearisome to list all of the names of the great and near-great with whom she has been in contact as helper, pupil, or teacher in the social and mental sciences.

As she enters her eighth decade, she would reminisce, and this work is a record of her thoughts, interlarded with much of her wide reading. She writes of infant memories, of home and school influences, of marriage, and of her children. Her husband was a natural-born teacher. She compares his method, as exemplified in the training of his own children, with those of later scientists—Gesell, Coghill, Koffka, and others.

*Feminism, Education, Mysticism, War Works, Evil as an Anachronism, Sociology, Mental Hygiene and Religion, The Chemistry of Humanity, The Unconscious, Remembering and Forgetting, What is Thought? Eyes and Spontaneity*—each chapter of the book represents focal points of interest with which Mrs. Dummer has identified herself as the years have gone by.

We find the book most stimulating and satisfying. The material is not very systematically presented, but too much system often robs a book of its charm. We accord this quality to the work of an earnest, interesting, sincere, and intelligent personality.

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WILL THERAPY: AN ANALYSIS OF THE THERAPEUTIC PROCESS IN TERMS OF RELATIONSHIP. By Otto Rank. Translated from the German, with a preface, by Jessie Taft. New York: A. Knopf, 1936. 291 p.

TRUTH AND REALITY: A LIFE HISTORY OF THE HUMAN WILL. By Otto Rank. Translated from the German, with a preface, by Jessie Taft. New York: A. Knopf, 1936. 192 p.

Those who are interested in following the details of Rank's departure from the Freudian system of thinking about the therapeutic relationship, and who have hitherto been unable to do so because of the unavailability in English of Rank's writings on this topic, can now turn to these excellent translations. Here also they can see where, from the Freudian standpoint, he has gone astray, partly from purely theoretical reasons and partly from not having sufficiently clarified his own point of view. There is much internal evidence of the books' having been composed in a hurry under the urge of strong emotional tensions. Because of this they contain a good deal of material that is irrelevant and confusing to the main purpose. Much of this extraneous material now seems clearly outdated and mistaken. Much of what Rank took to be lethal to the further progress of psychoanalysis has been shown by time to have been only a temporary difficulty. For these reasons the books will have for the most only an historical interest.

Yet there are points of theoretical importance that might well repay any one's attention. Psychoanalysts like to believe that their thinking is somehow not subject to the universal tendency to think in terms of a hypothetico-deductive system. But this simply means that they are unconscious of so doing. It is argued by some—*e.g.*, Reik—that such unconscious systematizing is somehow truer than conscious thinking would be. As to this we cannot yet say. In any case Rank has now provided a point of view from which further light can be thrown on this matter, even if the point of view is restated in the Freudian terms with which Rank took it to be in conflict. In the course of the composition of the section on the patient's reaction to the therapeutic situation (which forms Book I of *Will Therapy*) and the concurrently written *Truth and Reality*, Rank discovered certain epistemological difficulties which he attempted to work out in the *Seelenglaube und Psychologie*, after which he returned to finish *Will Therapy*, with the section on the therapist and the patient as complementary types. The epistemological difficulty in question—which is also a therapeutic difficulty—arises when the psyche, which is not a soul, in endeavoring to construct a conceptual picture of itself, begins to treat this as a soul —*i.e.*, as a conceptual picture with which to deny death. It becomes

something which in turn must be denied as being untrue to the individual.

The therapeutic situation as conceived by Rank can, perhaps not unfairly, be stated in Freudian terms as an elaborate flight to reality to escape internal difficulties, the therapeutic situation being an externalization of the patient's internal conflicts. The patient thus confronts in the analyst his Other (id, ego, or super-ego, whichever at the moment it happens to be, but in no case merely the object). But this effort to unload on the analyst creates emotional difficulties, especially of the guilt type, which are both new and real. Just here lies one of the principal distinctions between the Freudian and the Rankian points of view, the former view being that these emotions are not new, but are reëditions of emotions belonging to old situations now being rehashed; the latter that, in the main, the emotions are not memories, but are new, originating in the dynamics of the therapeutic situation, which is not merely a repetition of old, previously unworked-through situations. The effort to cast these emotions as reminiscences is, in part at least, an effort at defense against them. Thus where, to put it perhaps too sketchily, Freud took the conflict, external or internal, to be that between the id and its object, Rank takes the conflict to be that between the impulse-hostile ego and the impulses. If this characterization is correct, it may be seen that psychoanalysis has lately come to take a position somewhat similar to Rank's.

It is not possible in the space of a brief review to do more than indicate some of the basic differences in the two systems of thought. In the Freudian system, the id, with its libido cathexes and their vicissitudes, a biological conception, forms the basic material from which the theoretical picture is built up. In the Rankian system, the point of departure is the ego, with its urge to form a world to its liking, and the difficulties into which the ego gets itself in thus creating a world and trying to live with it, when the inevitable and inexorable onward urge of its creative will impels the creation of a new world or of a new soul (in some respects, the two are synonymous). Rank thus makes no use of the libido concept, and so his view of the nature of defense is quite different from the Freudian. Since systems of thought not only serve to arrange in order the facts we observe, but determine the very selective observation of such facts, our attention is taken by the number of clinical facts that Rank neglects or discards as hypostatizations of Freudian theory. Regression, for instance, is so treated.

On the other hand, some equally palpable facts of clinical observation here come into their own—for example, the guilt of being an individual, which receives insufficient or no attention from the Freud-

ian standpoint. It was consideration of this feeling in its relation to the situation of separation from a supporting medium that led Rank to the concept of the creative will and its accompanying guilt feeling. On the whole, however, the omissions to be noted in the Rankian system are bound to strengthen the impression that his system is built up on a too hasty and inadequately supported generalization of a partial view of the field. He himself once said somewhere that he came to his views from the analysis, not of severe neuroses, but of frustrated artists. However, he also said he was not interested in writing a science of the psyche, but in a philosophy of the therapeutic.

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ELEMENTS OF PSYCHOLOGY. By Knight Dunlap. St. Louis: The C. V. Mosby Company, 1936. 499 p.

After teaching courses in general psychology for a number of years, it was with great interest that I read Knight Dunlap's *Elements of Psychology,* a revision of his *Elements of Scientific Psychology,* published in 1922. I had hoped that this might prove to be the "ideal" textbook for beginners in the study of psychology. But after a careful reading and a critical rereading, I put the book down with a firm conviction that my hope had not been realized. For the benefit of those who are looking for a textbook for a class in general or elementary psychology, I should like to mention a few of the outstanding features of this book.

In the first place, this book does not confine itself to the "elements" of psychology, as its title would suggest. It is a scholarly and comprehensive survey of the principles of psychology presented in technical, scientific terminology, on the whole somewhat too difficult for beginners to grasp. As Professor Dunlap says in his Preface, he has "not attempted to prepare 'easy steps for little feet.'" In general, perhaps less than 25 per cent of the average class of beginners in psychology would be able to get as much from this text as they would from a slightly less technical book. On the other hand, the lack of experimental data as well as the paucity of references to experimental studies render the book unsuitable for the use of a class of students who have already had a background of psychological training.

Secondly, the more or less constant reference to the physiological basis of mental activities shows fundamental characteristics of activities too often dealt with so simply in most elementary texts that their true significance is not completely grasped by the student. It seems a pity, however, that Professor Dunlap has devoted so much space in the first part of his text to the physiological aspects of

psychology that students will be apt to wonder if "psychology" is not just another name for "physiology."

Thirdly, some of the topics generally discussed in elementary textbooks, and on the whole universally popular with the beginner, such as "feelings and emotions," "measurement of intelligence," "studies of heredity and environment," etc., are dealt with very briefly, while more technical and consequently less interesting topics, such as the "senses," "types of reaction," "perception," etc., are treated in more detail. From my experience in teaching beginners, it would seem wiser to emphasize the less technical points first and then gradually, as the student's grasp of the subject increases, place greater emphasis on the more technical points.

Fourthly, the "notes" at the end of each chapter are excellent and give a more detailed explanation of certain technical points than would be possible in the body of the text. This, it seems to me, is a form of textbook writing that could profitably be imitated by many writers of textbooks designed primarily for beginners. The references, likewise given at the end of each chapter, are quite adequate for an elementary textbook, but the omission of the names of publishers as well as of dates of publication makes it difficult for students to find the various texts or to know whether they are new or old publications.

Finally, the glimpse of abnormal psychology given in the last chapter of the book, *Maladjustment and Readjustment*, is a splendid innovation because it shows the student the relationship between the normal and abnormal. The student of elementary psychology will, I think, find it one of the most interesting chapters of the book.

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HOW TO USE PSYCHOLOGY IN BUSINESS. By Donald A. Laird. New York: McGraw-Hill Book Company, 1936. 371 p.

PSYCHOLOGY OF HUMAN RELATIONS FOR EXECUTIVES. By J. L. Rosenstein. New York: McGraw-Hill Book Company, 1936. 273 p.

The translation of the scientific facts of psychology and its laboratory results into meaningful concepts and guiding principles for business organizations, with particular emphasis on their application to the problems of supervisory and management personnel, has been attempted by laymen, journalists, major executives, prominent business leaders, and psychologists. Many writers have attempted to cover the field too vaguely and in terms that are too general. The attempts by psychologists, on the other hand, often have been too detailed and the illustrative samples selected have been difficult for business people to translate into meaningful concepts for the every-

day guidance of business. The writers of the two books in this review have attempted to bridge the gap.

It is Dr. Laird's hope that the point of view developed in his book may enable every executive eventually to become his own psychologist. He holds that it is necessary for business leaders to recognize that in dealing with human relationships the problem lies in the hands of the executive; the executive must be his own psychologist and "can make use of psychology for his own purposes even in the most backward firm, which is set against all newfangled things."

Dr. Rosenstein, on the other hand, is of the opinion that the psychologist can be of help in a business organization and must be regarded as an essential part of the program of developing the psychological attitude and point of view in the organization.

He recommends a psychological program for industry. In one phase of this, which he terms the horizontal, the principal aim would be to give all persons within the group training in the basic principles of psychology and mental hygiene through an extended series of lectures. After these lectures he recommends a series of discussions in which specific problems would be discussed covering various types of human relationship in business, with consideration of their solutions. A list of seventy-nine such problems are listed.

The second phase he designates as the vertical. In this, effort would be concentrated on the work of each separate division of the organization, so that each division head, together with his department heads and their employees, would come up for particular consideration. The psychologist would first interview the various executive heads and present a series of questions concerning types of problem. After these interviews, an attempt would be made to segregate certain types of individual for special interviews and in some cases for therapeutic work.

Both of these phases obviously stress the clinical point of view in industry. The emphasis is on a better understanding of human relationships and the maladjustments of workers through the study of personalities and clinical psychology.

Dr. Laird's book emphasizes the experiences of psychologists for many years in applying their science to industry. The aim of this book is to correlate psychological knowledge with the social, economic, cultural, and political problems of the day. Although the book considers methods of selecting employees, much of the emphasis throughout is placed on helping employees, on the motivation of workers, and on the development of personality. The personal efficiency of workers also is considered, and there is an account of some experiments conducted by the writer with regard to diet, eating habits, and work.

A number of personality questionnaire forms are included in various parts of the book.

Both books are written for a wide audience. Dr. Laird's presents facts in a dramatic fashion and is copiously illustrated with pictures and graphs so as to make the reading of interest to various types of supervisory and management personnel. Dr. Rosenstein's, on the other hand, is written as a practical manual for guidance in the directing of human relationships and bringing about a better understanding of the relationships in industry. Both books present many facts from various technical sources. Dr. Laird has attempted to give due recognition to the authors and references to sources of information. Such references are conspicuously lacking in Dr. Rosenstein's book.

To the readers of this journal both books are of particular interest because they discuss the development of psychology in the direction of dealing with a variety of mental-hygiene problems. They emphasize particularly the many objective techniques that psychologists have developed in the laboratories and are attempting to apply in industry. With due regard for their popular treatment, both may well find a place in the libraries of psychiatrists, clinical psychologists, industrial psychologists, vocational-guidance counselors, foremen, supervisors and business executives, and others who are concerned with the problems of employer-employee relationships.

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PSYCHOLOGY OF FEELING AND EMOTION. By Christian A. Ruckmick. New York: McGraw Hill Book Company, 193. 529 p.

The first hasty examination of this volume leaves a false impression. The illustrations, the introductory chapter in words of one syllable, and the summaries and neat lists of review questions at the end of each chapter suggest an elementary text. Superficial appearances, however, are deceiving, and any who desire a predigested treatment should avoid this book. Instead, it is a very thorough and scholarly survey of feeling and emotion, with a large emphasis on historical backgrounds, systematic theory, and scientific methods and findings. As such it will be welcomed by academic psychologists both as an advanced text and as an important contribution to the systematization of one of the most disorganized sectors of the whole field of psychology.

Whether this contribution can serve the needs of the students of human behavior who are less concerned with academic, theoretical, and systematic points of view depends on the student and his approach

to the volume. The content falls into three parts. Chapters II to VIII are concerned with historical views, definitions, classifications, theoretical problems, modern theories, and the author's formulation of his phylogenetic theory. The chapters on elementary feeling and the James-Lange-Sergi theory are masterpieces of historical orientation and critical exposition. Chapters IX to XIII explain methods of studying feeling and emotion and review a vast range of findings. Chapters XIV to XIX discuss implications for pathology, psychoanalysis, child and animal psychology, education, and the arts.

This reviewer suggests that the proper approach is to read the volume backward, beginning with conclusions in Chapter XX and implications in Chapters XIX to XIV and following with definitions in Chapter III, the James-Lange-Sergi theory in Chapter VI, and the author's phylogenetic theory in Chapter VIII.

The original contribution of the author is his careful formulation of the phylogenetic theory. This may be most conveniently stated in the form of two propositions: 1. Originally, in the lowest forms of animal life, the elementary feelings and the first dawning consciousness were identical. 2. As the equipment of sense organs and nervous system gradually emerged and the mental life developed, more specialized and complexly organized ranges of feeling, emotion, and sentiment developed in parallel course, permeating and making use of the new equipment and hence not requiring special receptor and effector mechanisms. This theory, better than any other, accounts for the inherent nature of the elementary feelings — their vagueness and lack of objectivity; their qualitative nature, permitting description only in terms of pleasantness and unpleasantness; their uncertain status as elements or as attributes of elements; and their intimate attachment to the more primitive organic and kinæsthetic sensations. The theory embraces the whole range of effective phenomena, from the most indefinite non-cognitive feelings of comfort and discomfort to the most abstract sentiments.

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A STUDY OF MASTURBATION AND THE PSYCHOSEXUAL LIFE. By John F. W. Meagher, M.D. Third edition, revised by S. E. Jelliffe, M.D. Baltimore: William Wood and Company, 1936. 180 p.

Masturbation or auto-erotism, sexual self-gratification, has received adequate scientific study only in recent years, dating from the publication of Havelock Ellis' revised volume on the subject in 1910. The practice itself, however, has been almost universal in the human race at all times and places, and is common in many mammalian

animal species. Among various peoples in the ancient and modern world, it has been sanctioned by the mores; but in our western civilization it is generally stigmatized as sinful, immoral, antisocial, abnormal, and injurious to body and mind. In spite of this conventional disapproval, recent reliable estimates indicate that masturbation is or has been practiced by 90 per cent of males and a possibly slightly smaller percentage of females in our culture. Here we have an almost universal practice which is almost unanimously condemned—truly a remarkable situation.

Dr. Meagher's book attempts to enlighten us in regard to this puzzle, but the effort is not successful. The cause of this failure lies in the author's confused state of mind (apart from the bad English of his writing). His underlying conventional morality is ever at war with his scientific facts, so that his whole treatment is inconsistent in tone. Again, his approach is primarily psychiatric and psychoanalytical, so that he fails to distinguish clearly between the occasional abnormal "patient" and the rest of humanity. Finally, and most important perhaps, he nowhere considers ordinary autoerotic practice—namely, moderate masturbation performed for pleasure and sexual relief among the millions of normal people, male and female, young and old, who at the time lack the facilities for coitus. It may be remarked in addition that nothing is gained in the way of clearness by referring to the erotic thoughts and memories that normally accompany masturbation as "infantile fantasies." Such terminology simply gives a false psychopathic flavor to a common phenomenon of normal humanity. It is properly applicable only in cases where the individual pathologically substitutes revery for available reality and thus tends to approach madness.

About one-half of the book is devoted to sex instruction and the psychoanalytic theory of individual development. This portion is so poorly organized that the reader finishes it with no very clear impressions. Possibly the main conclusions are that "we should try to make a fine moral and social unit of every child"; "instinctive cravings are always strong"; "sublimation must be stronger to control them"; and "the genital craving" should be diverted "to other estimable paths." Development is traced through four stages: the auto-erotic, first to fifth year; the narcissistic, sixth to twelfth; the homosexual, twelfth to sixteenth (or eighteenth); and the heterosexual, coming thereafter. The reader must look for himself to find out how "the modified homosexual component hostilities are converted into friendships," thus accounting for "Alumni Associations and the Knights of Columbus."

Reaching masturbation at last, the author becomes even more chaotic and repetitious than before. The lay reader will find it im-

possible to make clear sense out of the undigested conglomeration of Freud, moral notions, snatches from Moll, Stanley Hall, Jones, *et al.*, and scattered items of correct, up-to-date science, that constitute Chapters 5 to 8. After an inadequate account of methods of masturbation, the author discusses "symptoms and sequelæ," continuing to confuse the mental, the moral, and the physical, and constantly making extreme, unsupported statements. For example, he says that "a woman having no ethical conflict about her acts may escape a neurosis for a time, but not ultimately," and that coitus with affection and masturbation "have nothing to harmonize one with the other."

Treatment is discussed at some length, and here again confusion reigns. The author's knowledge that masturbation is "physiological" (*i.e.*, normal) in childhood and adolescence, his notion that it is "always deleterious in adults," his belief that it should be "cured" even though coitus is unavailable, and his faith in "sublimation," all combine to leave a most unsatisfactory impression in the reader's mind. Child training is brought up again in this chapter, and the author offers various "treatments"—religious, social, physical, and medical. He seems to rely chiefly on work, studies, games, music, and "innocent pleasures," having little or no confidence in medical and surgical procedures.

This book contains, perhaps, most of the important truths about auto-erotism, scattered here and there, but it is so poorly conceived and written that only an expert can pick them out. The lay reader will find more enlightenment in the Stones's *A Marriage Manual*, while the professional student should consult the works of Dickinson and Ellis.

H. M. Parshley.

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Abortion, Spontaneous and Induced, Medical and Social Aspects. By Frederick J. Taussig, M.D., F.A.C.S. St. Louis: The C. V. Mosby Company, 1936. 536 p.

Dr. Taussig, professor of clinical obstetrics and clinical gynecology at the Washington University School of Medicine, St. Louis, is the man in the United States best qualified to write this book. His interest in the subject antedates the year 1910, at which time he wrote the first special monograph on abortion. The present volume is one of a series dealing with the medical aspects of human fertility, sponsored by the National Committee on Maternal Health.

Despite the opprobrium placed by the laity upon the word "abortion" and the general lay employment of "miscarriage," the two terms are synonymous. Abortion should be defined as the "detach-

ment or expulsion of the previable ovum." Both spontaneous and induced abortions are recognized. The latter type is further subdivided into therapeutic and criminal abortions.

"Abortion has become a world problem. From both a medical and a social viewpoint, largely as a result of the World War, this question is engaging the serious attention of every physician interested in the preservation of maternal health." The scope of the problem can best be realized by quoting the author's estimates of the annual number of, and the death rate from, abortions in the United States. Evidence from three independent sources has been used to estimate this yearly wastage of maternal lives: (1) the total number of abortions; (2) the abortion death rate; and (3) the total abortion deaths. Inasmuch as 1 times 2 closely approximated 3, the resulting estimate was concluded to be reasonably reliable. The annual number of abortions in the United States is estimated to be 681,600, or about *one abortion for every three live births.* Forty years ago the ratio was about one abortion for every seven live births. Of these 681,600 annual abortions about 60 to 65 per cent are illegally induced, and 1.2 per cent of all the women suffering abortion, whether spontaneous or induced, die. This rate represents *a yearly wastage of over 8,000 maternal lives* and these figures are believed by the author to be minimum. Abortion, therefore, constitutes the greatest single factor in our high puerperal mortality, one-fourth of the total amount. "The vast majority of all abortions, equaling 90 per cent, occur among married pregnant women, especially those between twenty-five and thirty years of age who have had several children. The recent increase in abortions has been primarily in this group." It is, therefore, readily inferred that economic distress is a compelling force, causing married women to resort to the dangers of abortion in an effort to limit the size of their families.

The book is divided into four parts: (1) *History and Background;* (2) *Spontaneous Abortion;* (3) *Induced Abortion;* (4) *Social Aspects of Abortion.* It contains 146 illustrations. In addition there is an appendix, detailing the statutes of the federal government and of the several states relating to abortion. Part I contains a chapter written by Dr. Walter Long Williams, Professor Emeritus of Veterinary Science at Cornell University, on abortion in animals, and Part IV a chapter on legalized abortion in the Soviet Union. This chapter includes the description of a Russian abortarium in action, which was originally published in the *American Journal of Obstetrics and Gynecology,* after a personal visit of the author to Russia.

Further detailed description of this monumental and authoritative work cannot be given because of lack of space. Suffice it to say that

every conceivable avenue of approach to the question, including social, theological, and economic aspects, are thoroughly discussed. The medical aspects — physiology, pathology, etiology, prophylaxis, symptomatology, diagnosis, therapeutics, indications for therapeutic abortion, sequelæ, etc. — are handled in a masterful manner. The book is the most comprehensive compilation of data on the subject available and undoubtedly will remain the standard work for many years to come.

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AFTER THREE CENTURIES. By Ellsworth Huntington and Martha Ragsdale. Baltimore: Williams and Wilkins Company, 1935. 74 p.

This is a study of the changes in a group of people genetically connected that have taken place quantitatively and qualitatively from generation to generation during the three centuries since the United States was settled. As the genetic group, the Huntington family of New England is taken, starting from four brothers of the name who landed in Boston in 1633. Something over 4,000 persons are known who bear the name and are descended from these brothers, but probably over one and a half million persons are so descended. However, those who bear the name form a considerable group and it was this group that was studied. For "controls" were taken other Puritan types (names of Coolidge, Trumbull, Hooker, Lyman), partial Puritans (names of Edwards, Williams, Brown, Adams, Stone) and non-Puritans (names of O'Brien, Flood, Larson, Wagner, Schwartz, Russo, Cohen, and Levine). The incidence of these names in city directories which give the occupations of those named was determined and the occupations were tabulated. Also, *Who's Who*, medical, legal, and mercantile directories, patent lists, and other lists were gone through in like fashion.

The results are drawn up in masterly fashion, and it does appear that the families of Puritan origin have played a relatively greater part in the country's history than the partially Puritan and the non-Puritans. The importance of the genetical factor is once more brought out. For example (p. 110): "The near relatives of leaders are hundreds of times more likely to be leaders than are people in general." "The more nearly any person is related to an eminent leader, the more likely that person is to distinguish himself." If one hears a murmer of "privileged class," one must remind the murmurer that the greatest privilege is that of endowment with capacity for high intellectual and social attainments. The chapter on what

might have been had there been no immigrants after the colonial period and no forced labor is depressing reading. We might not have grown rich so fast, but we would have had less crime and pauperism.

The volume is a grand compendium of statistics as to the quality of our population and how it is being genetically controlled. Every lover of his country should read and digest it.

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# NOTES AND COMMENTS

*Compiled by*
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## ANNUAL MEETING OF ORTHOPSYCHIATRISTS

Twelve hundred psychiatrists, psychologists, social workers, educators, and others interested in the scientific study and treatment of behavior disorders participated in the Fourteenth Annual Meeting of the American Orthopsychiatric Association, which was held at the Hotel Roosevelt in New York City, February 18–20, under the presidency of Dr. Edgar A. Doll, of the Vineland (N. J.) Training School. It was the largest attendance ever attracted to the conferences of this dynamic and growing organization of professional workers in child guidance and related fields. Despite its youth, the Association has already established a tradition for the originality, depth, and scope of its scientific contributions, and this year's program more than lived up to that reputation in the interesting and varied papers presented and the lively discussions they stimulated. The topics ranged over old and new territory, from relationship therapy, social case-work techniques, and studies of infancy at one end, to summer camps, juvenile recidivism, fairy tales, finger prints in relation to biological factors, and suicide, at the other.

A new alliance of science and the arts in the study and treatment of conduct disorders was reported by Dr. Lauretta Bender and Adolph Woltmann in a paper on "The Use of Plastic Material as a Psychiatric Approach to Emotional Problems in Children." Through experiments conducted in the Children's Observation Ward of Bellevue Psychiatric Hospital, it was discovered, Dr. Bender said, that clay modeling, in which nearly all of the 700 children on this ward freely engage, offers an effective means, superior to drawing and similar art forms, by which children with behavior disorders work out their problems and, through the insight and emotional release gained in the process, arrive at a better adjustment. Plastic work thus becomes a valuable tool in treatment, supplementing the verbal means usually employed in psychotherapy, and making it easier in many cases to apply such therapy.

Other aids in clinical work that may lead to earlier detection of maladjustments and to the prediction of asocial conduct in childhood and later life were reported by Dr. Nathan W. Ackerman, of Topeka, Kansas, who described his studies of "normal" and "problem" children in an experimental controlled play situation in which construc-

tive and destructive tendencies were observed. He found that the performance of the child in this situation was characteristic of his general behavior, and that there was usually a striking correspondence between the quality of the socially constructive or destructive behavior in real life and the specific character of the performance in the experiment.

His study, Dr. Ackerman believes, will be of value in several directions. "It seems able," he says, "to give us additional knowledge of the specific modes of expression of constructive and destructive tendencies. It also facilitates a more graphic understanding of the antithetical relationship of these two sets of impulses. Moreover, if the close correspondence between clinical and laboratory behavior proves in further studies to be a consistently reliable one, it is conceivable that the test may prove useful as an auxiliary diagnostic, possibly even prognostic, aid in behavior disorders in children." Depending on the specific quality of a given child's constructive-destructive performance, it may lead on the one hand to a prediction of the character and intensity of that child's socially constructive or aggressive-destructive strivings, and on the other hand, may serve as a quick clue to the detection of maladjustment and of certain types of deviated character traits.

Fairy tales of childhood play a significant rôle in character formation and the development of neuroses in adult life, according to Dr. Sandor Lorand, New York analyst. Assuming the purpose of fairy tales to be to socialize children through entertainment, Dr. Lorand declared that the manner of telling the stories, as well as their content, has much to do with the states of pleasure or anxiety that accompany them. A savage tale, for example, told to intimidate, demands the complete surrender of all tender and even erotic tendencies in childhood. "In adult life this surrender may become the problem of a neurosis. Whereas a mild, helpful story, or one that is only incidentally or slightly threatening, may be a less acute problem in later life or none at all. Contrary to popular belief, such tales have grown out of folklore which has not come down to us through the generations with the sole purpose of amusing children, but deals primarily with the problems of adults." Pointing out their constructive value, he said that they fulfill children's wishes and have the same structure as dreams; their content is "really nothing more than the disguised realization of wishes."

Dr. Lorand's assertions were based on analytical treatment of various patients who recounted dreams in which fairy tales peopled with Lilliputian and other fantastic characters were a prominent feature. He described some of these dreams to show why such stories are

a source of pleasure and intellectual stimulation in one instance, and of neurotic disturbances in another, and how they create a permanent attitude in the child's unconscious mind and serve to sublimate childhood conflicts.

"We must take such dreams and the unconscious impulses and strivings they embody as an expression of some internal need," Dr. Lorand said, "and the special manner in which they contrive to carry over important childhood impressions in adult life must be looked upon as having a definite causal relation to the development of personality." Their significance in adult maladjustments depends chiefly on the circumstances under which the fairy tales were told the child—how much of them was acted out. If the child had not the opportunity to act out what he heard, but was left to digest the impressions created as best he could, the threatening elements in fairy tales may leave him with anxieties which may cause neurotic disturbances in later life.

A plea for more adequate attention to learning difficulties was made by Dr. Edward Liss, of New York, who defined educational activity as an expression of the biological functions of human beings, in no way different from those functions and closely interrelated and dependent upon them. All learning, he said, is a venture into the unknown, and this provokes varying amounts of fear and emotional disturbance which have to be neutralized in order that the learning process may move forward successfully. Fundamental to security, he added, are the early human relationships within the family, and as these relationships include intellectual as well as social experiences, the whole learning process is deeply affected by it, and this carries over into classroom relationships. In the final analysis, the purpose of the learning process is "to supply an adequate system of gratifications as substitutes for elementary biological functions, and the success of that acquisition is dependent upon the ability of the organism to resolve the conflicts involved in the accomplishment of that task."

Most of us are only about 25 per cent efficient, so far as our emotional relationships with others are concerned, and our enjoyment of human contacts is only about 35 per cent of what it might be. This statement was made by Dr. John Levy, who discussed the art of getting along with people in a paper on "Relationship Therapy." The backward state of human emotional development, "which shows itself at its worst in the intimate relations between two people at work, play, or love," Dr. Levy said, results in "a big waste in potential emotional and personality satisfactions and business efficiency." This waste shows up conspicuously in the industrial world, which "tries to be 100 per cent perfect in its impersonal activities, but accepts a 25 per cent standard in its methods of handling human

beings.'' The first step in developing a method for improving and enriching the feelings that humans have for each other, and for reducing dissension and friction between them, is ''to clarify the rôle each plays in any special and close contact.'' Dr. Levy showed how this is done by discussing the technique of ''relationship therapy'' used by psychiatrists in the treatment of patients.

New views of the age-old problem of suicide were presented at a special symposium conducted by Dr. Gregory Zilboorg on the subject of self-destruction among the young. The so-called obvious causes of suicide, like disappointments in love, loss of fortune, and so forth, do not seem to be operative among the young, Dr. Zilboorg said, the great majority of these suicides being ''impulsive, unexpected, and, therefore, particularly baffling.'' He suggested two sources of information which may shed some light on the problem: first, the child's family situation, and second, the ''suicidal habits'' among primitive races. Too much frustration, he said, produces ''an untold amount'' of inner, unconscious hostility or aggression, which, if not permitted to express itself in some legitimate way, will turn on itself and produce a potential suicide. And too much overprotection and family attachment may lead to the same results as severe frustration. On the other hand, suicidal attempts in adults often bear all the psychological earmarks of adolescence and ''impulsive primitiveness.''

The age of puberty seems to be the crucial period in the development of active self-destructive drives, Dr. Zilboorg said, because the rate of suicide increases with age, and more old people per unit of population commit suicide than young people. Childhood attempts at self-destruction are usually results of what appears to be fear or spite or both. And fear and spite are frequently the psychological triggers that release the suicide impulse in primitive and semi-civilized races. Incidentally, primitive people commit suicide more easily and more frequently than civilized people. And while suicide among civilized races is more prevalent among men, among primitive races it is almost monopolized by women. On the other hand, statistics show that among civilized people the rate of suicide before the age of sixteen is lower for boys than for girls, while after this age it is lower for girls.

''This is an important fact,'' Dr. Zilboorg said, ''since the psychic conflicts awakened during the age of puberty are of major significance in the structure and dynamics of suicide, and since the discrepancy in the incidence of suicide between the sexes might serve as an additional clue to the psychological riddle.''

In a statistical study of 1,000 delinquent boys at the juvenile court in Cleveland, Dr. Milton Kirkpatrick suggested some significant social factors which indicate whether children appearing in court for the

first time are likely to become "repeaters." The study was made in an attempt to furnish practical help to juvenile-court judges and probation officers in dealing more constructively with young offenders, and to enable them to identify those who are likely to become recidivists. His findings, he thought, "may sensitize case-workers to those social danger zones which seem to breed recidivism, and may make it possible to distinguish between the more promising subjects for probation."

Psychiatric studies of infancy, indicating "probable future behavior problems," were reported by Dr. Margaret E. Fries. Marked individual differences in babies, pointing to such problems, she said, were observed during the first ten days of life. By six weeks of age, it was found, definite trends and patterns of behavior were established, and these persisted throughout the first six months unless modified by therapy, usually through psychiatric treatment of the mother.

That character formation is to a great extent dependent upon childhood experiences, Dr. Fries said, has been proven mainly through the study of pathological conditions, wherein childhood has been recalled or reconstructed and contributing factors have been determined. In her study the approach was the opposite of this. Instead of treating undesirable character traits after they had arisen, she studied and dealt with "character in the making," by following the growth and development of 47 infants attending the Well Baby Clinic at the New York Infirmary for Women and Children, beginning nine years ago.

Throughout the investigation continuous observations as well as predictions as to possible future development were made, and based upon these, medico-psychological therapy and prophylactic measures were administered. Such treatment was found to be of great value in obviating or alleviating problems of emotional adjustment, even during the lying-in and early-infancy periods. For example, difficulty in nursing often set up a tacit struggle between mother and child, which might have been carried through childhood in one form or another if not handled immediately.

The simultaneous and comparative study of causation and development in both normal and abnormal cases proved more helpful than studying these types separately, Dr. Fries said. By investigating pathological conditions it was easier to see causes and effects in development; and the study of normal cases was illuminating because the opportunity for making such a study is rare, since cases of this type do not ordinarily come to the psychiatrist.

The oldest of this group of children is now eight years of age, and it is planned to continue the study through adolescence, in order to observe their ultimate adjustment and to evaluate the validity of the

predictions made and the efficacy of the therapy administered. On the basis of this research to date, however, Dr. Fries concluded, "it can safely be said that one does not have to wait for the infant to develop tantrums, the boy to land in court, or the adult to be placed in a mental hospital. During early infancy and childhood certain trends may be observed which enable one to foresee probably, though not absolutely, problems which are liable to interfere with satisfactory development. Once on the alert for such possible maladjustments, preventive measures may be taken."

"Direct Treatment in Social Case-Work" was discussed by Dr. Paul Sloane, of Philadelphia; "The Treatment Possibilities of Summer Camps," by Joseph Galkin, of New York; "The Problem of Treatment of Aggressive, Criminal Behavior in Passive, Effeminate Boys," by Dr. Martha W. MacDonald, of Chicago; and "Culture and Personality," by Dr. Franz Alexander, of Chicago.

In his presidential address, Dr. Doll said it was essential to progress in child-guidance work that psychiatrists study "not only problem children, but children's problems." Only a few studies, he said, have attempted to show the "positive" side of the picture—for example, the extent to which behavior problems are present in children whom we would not call problem children, the extent to which these problems spontaneously clear up, the extent to which parents are not "reprehensible," and to which substitute parents do well by their foster children.

The following officers of the Association were elected for 1937–1938: *President,* Dr. George J. Mohr, of Chicago; *Vice-President,* Miss Elma Olson, of Evanston, Ill.; *Secretary,* Dr. Norvelle C. LaMar, of New York; and *Treasurer,* Dr. George S. Stevenson, of New York. The fifteenth annual meeting will be held in Chicago on February 24–26, 1938.

## Human Relations

Some five hundred friends and supporters of the Associated Charities of Cincinnati, attending the annual dinner meeting of the organization last fall, were given an interesting glimpse of the activities of the Yale Institute of Human Relations by Dr. Mark May, Professor of Educational Psychology and Director of the Institute, in the course of an address on "Scientific Approaches to the Problems of Social Work." It was the thesis of his address that the focal point of human need is always the individual in a situation which includes not only the physical and social elements present, but also the background of traditions, beliefs, and other cultural elements.

The fact that this focal point is always the individual, but that the

study of the individual includes also the study of his environment and culture, Dr. May said, was illustrated by certain studies that have been carried on at the Institute of Human Relations, among which he mentioned particularly Dr. William Healy's investigation of the problem of delinquency. This study, which covered 133 families selected from the cities of Boston, New Haven, and Detroit, dealt with the question as to how it happens that one child in a given family will become a delinquent and the other children remain law-abiding. Dr. Healy found some form of maladjusted human relationship existing in practically all of these families, which represented a cross section of the middle and lower classes of society, only 16 per cent of them having been dependent on public aid at the time of the study. The answer was that the family maladjustments acted differently on different children in the same family. "The delinquent child always appeared to be the one who seemed to get the bad breaks and who was caught in the network of maladjustment more seriously than his non-delinquent brothers or sisters," Dr. May said. "At least he was less able to adjust himself to the family maladjustment."

By a long process of friendly relations with these families, Dr. May continued, Dr. Healy and his staff were able to accumulate bit by bit a body of knowledge concerning the pattern of human relations which characterized the life of the families. They were able to show that delinquency arises fundamentally from the fact that whenever a child is unable to derive basic satisfactions from his home experience, he will automatically seek other channels for securing these satisfactions. "If his mind is open to the acceptance of ideas of delinquency from others, then he is drawn into delinquent behavior by social forces which seem to be as universal and powerful as the force of gravity in the physical universe."

As a matter of fact, Dr. May pointed out, Dr. Healy and his co-workers could reshape, rearrange, and adjust the system of relationships in many of these families so that in the new system the child would find, not necessarily more physical comfort, but more emotional satisfaction, and when this happened, the cause of delinquency was removed and the delinquent behavior disappeared. "This investigation," Dr. May said, "convinces me that the problem of human relations in families can in fact be solved, but the solution requires a tremendous amount of time, effort, and money per family. But when I think of the cost to the state of crime, insanity, and divorce alone, I am convinced that any amount of money that a community can put into work of this sort can pay huge dividends in the end."

The study also revealed, Dr. May went on, that the biological struc-

ture of the individual is an important factor in determining his human problems; that his environment may or may not be suitable to him; and that he may be caught in a current of social forces which determine his environment and consequently condition his behavior.

At the present moment, according to Dr. May, the social sciences are much better equipped to deal with these larger currents than with the specific problems of individuals. In this connection he pointed to the various New Deal agencies which showed, on the one hand, the extent to which the sciences of engineering and medicine can be used in dealing with national problems and, on the other hand, how little the sciences of psychiatry, psychology, and sociology can help. As an example, he cited the T.V.A., which was able to solve its engineering problems in the construction of dams and power plants, and its economic problems in the distribution of electric power, but when it came to the human problems, "there seemed to be no scientific principles on which they could rely with the same certainty and confidence."

The absence of an adequate human science, Dr. May said, was clearly revealed in the government relief agencies, as when the government decided to shift from the F.E.R.A. to the W.P.A. on the assumption that the "dole" tended to have a pauperizing effect on its recipients. But the problem as to whether F.E.R.A. was better or worse for the country than W.P.A. is one that could not be solved by the application of scientific principles, "for the reason that no such principles are available. Laws that would enable us to understand and predict the behavior of individuals in specific situations do not exist except in a very general way."

There are numerous deep-rooted conflicts and paradoxes common to all cultures and societies that exert a tremendous influence on human adjustment, Dr. May continued, and the problem of how to educate individuals so that they will enjoy the things that are approved by society and will not enjoy the things that are disapproved "has always been and will continue to be the essential taproot of the matter." In other words, the process of becoming socialized involves basic frustrations of our instinctive tendencies, and nearly all human-relations problems grow out of our failure to adjust to these frustrating experiences. And while the problem of the social worker is essentially the problem of readjusting, rearranging, and reshaping complex patterns of human relations, so that individuals involved in them will find more permanent satisfactions, there are at present no scientific prescriptions that can be written for the cure of human maladjustments. Family case-work is, therefore, more an art than a science, though by long experience and by

critical insight, family case-workers often become quite expert in diagnosing and treating human problems. "There is a minimum amount of scientific knowledge which is available and useful, and it is the hope of the Institute of Human Relations and other similar organizations," Dr. May said, "to increase this body of scientific knowledge and place it at the disposal of practitioners."

While the economic problem is frequently a complicating factor, as in the lower-income groups, it is not always or necessarily the fundamental cause of human-relations problems, because even when the economic problem has been solved, the basic human-relations problems often remain untouched. Hence the need for family social work, as there is not now "and probably never will be" any way of handling these problems by legislation or by large social reforms. Better housing, better social legislation, such as unemployment insurance, and so on, he said, will help in a general way, but such legislation bears the same relation to human relations as sanitation laws bear to medical problems. "While it is true our present system of social legislation is entirely inadequate and many legal reforms are necessary," he concluded, "it is equally true that even if our laws pertaining to social reforms were ideal, we would not automatically eliminate the necessity for such organizations as family-welfare and social agencies, any more than sanitation laws eliminate the necessity for practicing physicians."

### Loose Living and Loose Thinking

The problem of the control of syphilis and gonorrhea has now become primarily a psychological one, since it depends more on public education and the dissemination of new ideas and attitudes than on the available medical knowledge as to methods of treatment and prevention. This statement was made by Dr. Karl Bowman, Director of Bellevue Psychiatric Hospital, at an all-day Regional Conference on Social Hygiene held at the Pennsylvania Hotel, New York City, on February 3, under the direction of the New York Tuberculosis and Health Association, and attended by 3,000 representatives of 48 public and private agencies which sponsored the conference. Similar regional and local conferences were held at the same time in 200 other cities throughout the country in observance of National Social Hygiene Day.

Dr. Bowman spoke at a special mental-hygiene session, one of the many section meetings, devoted to various aspects of social hygiene, into which the conference program was divided. Juxtaposing the two subjects, he said that mental hygiene stressed how personal health is affected by "loose thinking," while social hygiene emphasizes the effects of "loose living." He deplored the taboos that still condition man's way of dealing with venereal disease and condemned the "emo-

tional and unintelligent attitudes'' that hinder progress toward its eradication. We know its causes, he said, and we know how to cure and prevent it, but we cannot apply this knowledge because of the ''powerful forces in society which oppose clear thinking among the masses of our population.''

It is not the maligned ostrich, but civilized man that ''hides his head in the sand,'' by refusing to think clearly about the problem and to face the facts. ''We have been trying to solve the problem of loose living by loose thinking,'' Dr. Bowman said, ''with results that have been anything but satisfactory. For years we have known the cause of syphilis and the cause of gonorrhea. We have efficient means of treating these diseases after a person has once been infected, and we know how they are transmitted. Yet we have allowed these diseases to remain epidemic throughout our population and have not been able to apply our knowledge due to the emotional and unintelligent attitude which has prevailed generally.'' Sex is one of the strongest instincts we have, he added, one of the greatest driving forces in determining behavior, yet ''many persons would have us try to understand human behavior without any reference to sex.''

It is this ''conspiracy of silence'' regarding sex, carried over to syphilis and gonorrhea, that has prevented a free and frank discussion of these two diseases and an intelligent and efficient dealing with the problem, and psychiatry is interested in studying the causes of this. Another reason for the common interest of mental hygiene and social hygiene in the problem, Dr. Bowman pointed out, is the fact that nearly 10 per cent of all admissions to mental hospitals in this country are due to syphilis of the nervous system, the elimination of which would reduce mental disorders by so much.

The discussions at these regional conferences were centered largely about the findings of the Surgeon General's Conference on Venereal Disease Control held in Washington last December, when a program was adopted for a vigorous national campaign against syphilis and gonorrhea. It was then estimated by Dr. William F. Snow, General Director of the American Social Hygiene Association, which is the driving force back of this campaign, that about 6,000,000 men, women, and children are infected with syphilis, ''although not one in ten is under treatment by a licensed physician,'' and that the amount of gonorrhea is more than twice as great. Dr. Snow confidently expected that 1937 would see greater progress in reducing these diseases than in any year since the World War, due to a number of encouraging factors, among them the increased funds now available for this purpose to the Public Health Service and the Children's Bureau

through the Social Security Act, and the heartening change in attitude of the newspapers and popular magazines toward a freer and franker discussion of the subject.

### "The Mentally Ill in America"

Probably no phase of our social history presents so shocking and persistent a record of "man's inhumanity to man" as the story of his treatment of the insane. Readers of *A Mind that Found Itself* will recall the unfortunate conditions that prevailed in the average American asylum of even a generation ago. Now, for the first time, the whole dramatic story of man's struggle with mental disease in America, from Colonial times down, is told within the covers of one book, to be published this spring, under the title *The Mentally Ill in America* by Doubleday, Doran. The book shows the changing attitudes toward mental illness that shaped methods of treatment at various historical stages, and describes the slow, up-hill progress from the early confused mass of superstitions and folk remedies to the scientific methodology of twentieth-century psychiatry.

Dr. William H. Welch once said that the proper approach to any medical subject is the historical. Oddly enough, until now there has never been available an adequate and readable, as well as reliable and authoritative, work to which students could turn for the historical background of the field in which so much has happened during the past twenty-five years—that of mental hygiene. *The Mentally Ill in America* admirably meets this long-felt need.

The author, Albert Deutsch, has specialized in social-welfare history in the United States and because of his unusual qualifications for the task, was commissioned to write the book by The American Foundation for Mental Hygiene under a special grant made for the purpose two years ago. Since then he has made an intensive study of the evolution of psychiatric practice in this country from the earliest beginnings, going back to the original sources and records, covering in his researches a huge mass of books, reports, and documents of every kind, and bringing us the complete story right down to the present day. Mr. Deutsch has done a thorough and scholarly piece of work that has had the enthusiastic approval of the foremost leaders in American psychiatry. It will prove invaluable to professional workers in many fields and will undoubtedly serve as a standard reference text for years to come. But the layman, too, will find it an interesting and even fascinating work, written as it is in a non-technical, attractive literary style.

In his foreword to the book, the late Dr. William A. White says:

"It is an exceedingly illuminating presentation and because of the dramatic material with which it deals, it may well prove to be a spearhead for the penetration of important social facts and the understanding of social processes which, presented with less appealing or less startling illustration, might fail to attract attention. It should be widely read, for its message is of the utmost significance."

### Insanity and Insulin

Despite far-reaching advances in the treatment of the mentally ill during the present century, patients enter mental hospitals faster than they go out. The recurrent overcrowding in these hospitals bears grim testimony to the losing race between science and the building of new and larger institutions on the one hand, and a progressively increasing incidence of hospitalized mental disease on the other. Under these conditions we experience a natural thrill of reaction to any discovery that promises to quicken the pace of scientific progress in this field.

Such hope has been held out to us lately in connection with the insulin treatment of dementia praecox, that incubus of mental disease that weighs down the best of our struggling state hospitals, challenging the ingenuity of psychiatry to the utmost, and calling forth every resource of research and therapy it can muster in its attack on this perplexing problem.

The significant thing about this new treatment is the fact that it has aroused the optimism of our most conservative psychiatrists, who value it potentially beyond any other available thus far. Dr. Adolf Meyer, for example, says the results show that here at last psychiatry has at its disposal a way of attaining alterations "such as we never could have expected from any other means we know of," and mark the first success in breaking through what had seemed insurmountable obstacles.

The origin and nature of the treatment were described by Dr. Manfred Sakel, Vienna psychiatrist, at a joint meeting of the New York Neurological Society and the Section of Neurology and Psychiatry of the New York Academy of Medicine, held at the Academy on January 12. He discovered the treatment in 1928 when, accidentally, he observed certain mental changes in diabetic drug addicts whom he was treating by insulin at that time. It is known technically as the induction of a hypoglycemic state—an extreme lowering of the sugar content in the blood—which is produced by the injection of progressive doses of insulin. In the "shock" stage, the patient goes into a deep coma, which is relieved, after a few hours, by the administration of sugar. In the process, the patient's mental condition clears up.

How this happens is still a matter of conjecture and theory. According to Dr. Sakel, the hypoglycemia at first revives the normal personality of an acutely psychotic individual. Later, when the patient has improved, the hypoglycemia serves to revive the psychosis, which has been repressed, but not yet eliminated. But, after repeated treatments, these psychotic symptoms of hypoglycemia are themselves soon diminished and finally eliminated, so that the patient is at last symptom-free and the psychosis disappears.

The treatment seems to be most effective in recent cases of schizophrenia, of less than a half year's duration, though some improvements have been brought about in older cases. How permanent the "cures" will be, even in the earlier cases, time alone will tell. But the results so far secured in complete remissions of the disease are impressive, and experiments by American psychiatrists, described at the same meeting, seem to corroborate Dr. Sakel's findings. Aware of the hazards of statistical interpretation of the results, Dr. Sakel was cautious in presenting his claims. "But when," he says, "in so large a series of cases (300) as I have treated up to now, and with the results confirmed by others, the net result is a percentage of remissions which is at least four times greater than the most optimistic figures for spontaneous remissions, then I think, no matter how cautious we may be, we are entitled to conclude that the treatment is effective."

Promising as this new form of treatment is, we must guard against extreme expectations with regard to ultimate results. As has been said by the American Psychiatric Association in a recent statement on the subject: "It is hoped, and may prove to be a fact, that the so-called insulin shock treatment for dementia praecox will find a useful place among the forms of treatment, but its exact value has as yet to be determined." Mindful of past disappointments, the Association adds a note of warning: "It would be a source of regret should the insulin shock treatment be a means of holding out a false hope to the families of the tens of thousands of sufferers from dementia praecox when this hope most certainly cannot be widely realized with the present-day knowledge of insulin therapy. It is, however, at the present time receiving careful study in the New York and Massachusetts state-hospital systems, in Bellevue Hospital, New York City, and in other scientific centers."

### Institutional Accommodations in Maryland

Institutional accommodations for the mentally ill and defective in Maryland are characterized as "seriously inadequate" by a special committee of the State Medical and Chirurgical Faculty which was commissioned by Governor Harry W. Nice last year to make a pro-

visional survey of the situation. A cumulative deficit of beds and insufficient medical and nursing personnel are the principal deficiencies disclosed in the report.

Overcrowding has become progressively worse, despite the restrictions on admissions in force since the depression. On this point the report concludes that "while admissions to a Maryland hospital can usually be secured for patients with serious mental disorders of a disturbing nature, there is considerable difficulty at times and in certain places in securing admission for other patients whose symptoms are of a less disturbing character, but whose condition requires hospital treatment."

In requesting an emergency appropriation for a new building at one of the state hospitals which has a long waiting list of the seriously ill—an appropriation urgently needed "to provide for patients who are now uncared for or detained in jails and police stations"—the committee observes that "some tragedy is sure to occur among this group if no provisions are made for them within the coming year."

Frank comparisons are made with hospital provisions in neighboring states. "The standards of medical and nursing care," the report states, "while comparing favorably with those in backward states, are in general below those in general hospitals and other special hospitals, and with those in the mental hospitals of other states." The compensation and living conditions of the medical officers "are below what are necessary in order that Maryland may compete on equal terms with other states with better standards. . . . Maryland is employing fewer persons to care for patients and pays its attendants less than most of the surrounding states. . . . Maryland nurses must care for almost twice as many patients as New Jersey or Delaware nurses. . . . Maryland spends less than half as much per patient as some of the neighboring states." Other criticisms are as follows:

> Two of the four state hospitals are operating with only one registered nurse in each institution.
>
> For the past three years the hospitals have operated much below adequate maintenance levels.
>
> One institution has been operating on a purely custodial basis.
>
> There is at present a waiting list of nearly 300 for the institution for white mental defectives, and Maryland has fallen seriously behind in its provisions for this group.
>
> There are only 100 beds for colored mental defectives and these beds are not available for use because of lack of maintenance appropriations.
>
> The principle of occupational therapy seems recognized in the hospitals, but, owing to limited resources, this element in the treatment of patients is inadequately developed.
>
> The hydrotherapeutic installation in most of the hospitals is inadequate, and in none of the hospitals is there a trained hydrotherapeutist.

> There is a very serious lack of opportunities in the community for the early diagnosis and management of mental cases who are still living in the community.
>
> In none of the mental hospitals of Maryland was there evidence of their adequate development as community centers for after-care, preventive and educational work in mental hygiene, the number of social workers available being hopelessly out of proportion to the requirements.

The Committee concludes its report with the recommendation that an official commission be appointed to make "a thorough and intensive survey of existing conditions and future needs of Maryland's system for the care of its insane and feebleminded." Among the needs to be considered by such a body, it mentions a census of mental disease and defect, the creation of a new psychopathic hospital integrated with the University of Maryland Medical School, a separate institution for the adult feebleminded, an institution for defective delinquents, better provisions for the criminal insane, better defined central administration, and improved commitment laws.

### Conditions in North Carolina

With the passing of the economic crisis, which played havoc with their fiscal affairs and reduced public-health and welfare services in many instances to bare subsistence levels, state governments are reappraising their provisions for the care of the mentally ill in an effort to recover their losses, rehabilitate crippled institutions, and improve hospital and other treatment facilities in line with present and future requirements.

The North Carolina Commission for the study of the Care of the Insane and Mental Defectives, appointed by Governor J. C. B. Ehringhaus in 1935, has just completed an exhaustive survey of conditions in that state. The survey was undertaken after the adoption of a joint resolution by the house of representatives and the senate early in that year, when the state hospitals "had become filled to capacity and had large waiting lists, resulting in the confinement of many mentally ill people in jails and almshouses." We quote from the report of Dr. Lloyd J. Thompson, of the Yale Institute of Human Relations, who conducted the study under a special grant from the Rockefeller Foundation.

Overcrowding has been avoided only at the expense of refusing admission to hundreds of applicants, Dr. Thompson states, adding that patients were admitted much more readily in 1929 and 1930 than at any other time in the past decade, with the result that North Carolina has had a low ratio in number of hospitalized patients to general population compared with most other states since 1933. The fact that

there has been a waiting list of over 800 at the Caswell Training School, the state's only institution for the feebleminded, further emphasizes her arrears in beds. Hence the Commission's recommendation that a new state hospital be constructed, in addition to the three existing hospitals, as well as a second training school for mental defectives.

The Commission pays tribute to the fine work of the state-hospital superintendents during the depression years, in spite of the fact that their maintenance budgets were very nearly the lowest in the country. But this lack of funds militated severely against their ability to bring the level of service up to anything like the accepted standards of psychiatric care and treatment. Dr. Thompson notes, among other deficiencies, the low ratio of personnel to patients, the almost entire lack of social workers, of hydro- and physiotherapists, of recreational directors, and of other special personnel, the frequent recourse to seclusion of patients because of small nursing forces, the total absence of laboratories for pathology and research, of out-patient clinics, and of other community mental-hygiene activities.

Invoking the standards laid down by the American Psychiatric Association, with which he compares the present status of North Carolina's facilities, Dr. Thompson says: "These ideal standards are not met in all respects by any state, but several states approximate many of the requirements. For the present in North Carolina a goal of meeting what the average state of the country does should be set, but an ultimate goal of the ideal standards should be considered to be within the realm of possibility."

Considering the low percentage of her governmental expenditures allotted to public-welfare functions, and the very definite bearing of this on mental-health conditions in the state, North Carolina obviously has a long way to go in meeting the ideal. But, as Dr. Thompson says, "the same can be said with regard to many other states, and North Carolina has shown once more its progressive spirit and is ready to improve the situation as much as is possible in the light of present-day knowledge." In this connection, every state government might well adopt as a guiding principle the wise dictum of the Brookings Institute in the report of its recent study of state government in North Carolina, to wit: "Economy to the taxpayer can only come by keeping people out of institutions, rather than caring for them at a minimum cost after they get in."

The preventive implications of this advice are well brought out in Dr. Thompson's splendid analysis of North Carolina's mental-hygiene problem. His study, which is one of the most comprehensive and thorough ever attempted in any state, deals with every phase of the

problem: mental disease, mental deficiency, epilepsy, hospitals, clinics and other extramural activities, professional and public education, the schools and colleges, the mental-health aspects of crime, delinquency, and dependency, community organization, and so on.

To bring about better coördination and centralized direction of institutional activities, he proposes the establishment of a division of hospitals and medical service within the Board of Charities and Public Welfare, with a competent psychiatrist in charge. This would supplement the present division of mental hygiene, which "has made significant contributions to the correctional institutions, public schools and other fields of mental health activity," and which should be strengthened and expanded. As a further step in state organization, Dr. Thompson recommends the formation of a state mental-health council which would correlate the various government agencies now concerned with mental-health objectives. Finally, he urges a revision of the state laws relating to all psychiatric and mental-hygiene problems in line with modern concepts and practices. This is so important that he suggests the appointment of a special commission of lawyers, psychiatrists, and legislators to undertake the task.

### A Magazine for Teachers

After the lapse of a year, during which publication was suspended for lack of funds, *Understanding the Child*, the quarterly magazine issued by the Massachusetts Society for Mental Hygiene from 1931 to 1935, resumes its appearance as a regular publication of The National Committee for Mental Hygiene. This unique periodical, devoted to the mental health of children, has been a highly valued contribution to the instruction of teachers in the principles and practices of mental hygiene as applied to the classroom, and has had a wide circulation among the schools of Massachusetts. In recent years educators outside the state have begun to appreciate its excellence as a medium serving their special needs, with the result that there has been an increasing demand for the publication in other sections of the country. In one instance, for example, subscriptions were ordered in bulk for all the teachers of the school system in a large city. The National Committee now takes over the magazine in an attempt to make it available to elementary and high-school teachers the country over, and to implement the gradually developing program in the field of education, in which the Massachusetts Society has done such important pioneer work.

*Understanding the Child* begins its "return engagement" with the April issue, under the editorship of Dr. Henry B. Elkind, Medical Director of the Massachusetts Society for Mental Hygiene, and a

group of associate editors, assisted by a consulting editorial board composed of twenty authorities in the fields of education, psychology, and mental hygiene. "New Horizons in Education" is the theme of the issue, which will contain challenging original articles—on such topics as the ideal school, the nature of "guidance," the changing rôle of the teacher—stimulating editorials, lively book reviews, abstracts, case studies, and news items.

Promising us an interesting number, the editors tell us that they have spared no effort to produce a magazine that will be not only useful and readable, but artistically attractive, as well as intellectually satisfying, to teachers and mental-health workers alike. The subscription rate will be fifty cents a year (four issues) or one dollar for three years; single copies, fifteen cents. The editorial office of the publication is 3 Joy Street, Boston; the business office, 50 West 50th Street, New York.

### Three State Conferences on Mental Health and Education

Simultaneously with the publication of its first issue of *Understanding The Child,* The National Committee for Mental Hygiene is embarking on a series of state conferences on "Education and Mental Health," to promote interest and action in this field on a national scale. At this writing arrangements are being completed for the first conference, to be held at Wilmington, Delaware, on April 9 and 10. The second conference is scheduled for Detroit, on April 16 and 17; the third will be held in Philadelphia, April 23 and 24.

Nationally known leaders in psychiatry, psychology, mental and social hygiene, and elementary and higher education will address the conferences, which will represent the special interests of the various fields to be covered by the programs. The topics will range from the mental health of the teacher, the mental-hygiene implications of truancy, the relationship between mental health and cultural aims, to the dangers and advantages of sex instruction in the schools, the school's responsibility in regard to delinquent children, mental-health problems of the gifted child, and the prevention of mental disease. Prominent citizens and leaders in professional, educational, religious, social, and business life in these states and cities will participate in the various sessions, which will cater especially to parents and teachers, but will be open also to the general public.

The Delaware conference has been planned as a joint undertaking of the National Committee and the Delaware Society for Mental Hygiene, and will conclude with the annual dinner meeting of the Delaware Society. The Michigan conference will be held under the auspices of the National Committee and the newly organized Michigan Society for Mental Hygiene, which will conduct its first annual dinner

meeting on this occasion. The Pennsylvania conference will be in collaboration with the Mental Hygiene Committee of the Public Charities Association of that state.

### Four Neighbors

We are indebted to the Judge Baker Guidance Center of Boston for an addition to the all too meager supply of sorely needed pictorial publicity materials on mental health—a motion picture showing how problem children are studied and treated at this center, one of the foremost of its kind in the country. It is a silent, 16 mm., 50 minute film, entitled *Four Neighbors*. It tells the stories of four twelve-year-old schoolmates, each of a different nationality and from a different economic and cultural background, who present, respectively, a conduct problem, a vocational problem, a personality problem, and a family problem. The boys are sent by the school principal to the Judge Baker Guidance Center which, after months of treatment, finds a helpful solution for each of the problems.

Patsy O'Hara, a neglected boy, is brought to the juvenile court for stealing. His father is unemployed and unhappy after the death of his wife, and in his discouragement turns to drinking. He "takes it out" on the boy, who feels himself unwanted and rejected. The Guidance Center gives the father new courage and insight into his relations with the boy, and after a temporary foster-home placement, establishes a new family life and understanding, and Patsy no longer steals.

Hyman Markovitz is a problem in educational maladjustment. He is a poor student, but he has a talent for music. The father, frustrated in many of his own longings, has other ambitions for his son and wants him to study medicine, for which he is totally unfitted. Much of the lad's time is spent in phantasy, the content of which the film reveals. The Guidance Center makes it clear to the father that the boy can only suffer defeat and unhappiness under these conditions, and finally persuades him to let the boy follow his musical bent.

Frank Jones is the victim of an overprotective, aggressive mother. Disappointed in her husband, she tyrannizes over her son, who resents her domination, reacts by rebelliousness to all authority, and takes refuge from her nagging in dangerous phantasies of becoming a gangster. She is persuaded to give him more independence and outlets for his interests, and Frank, who is a bright boy, is greatly helped by the change in her attitude.

In the Catabria family we see the clash of two generations—over-restrictive, Old-World parents, well-meaning, but lacking in understanding, and overworked children, getting little or no rest or recreation, failing in school, and on the verge of delinquency. Months of

contact with the Guidance Center modify parental behavior, and the children get opportunities for new happiness and achievement.

The film was well received by Boston's public and highly praised by the newspaper critics. We have seen the picture and agree with them that it is excellently done, in spite of the fact that the actors —over a hundred of them—were all amateurs. It is a fine achievement, a vivid dramatization of a difficult theme, with the seriousness, pathos, humor, and other ingredients of an appealing human-interest story, which carries conviction and reflects great credit on the enterprise and ingenuity of the Judge Baker Guidance Center and the staff that produced it. Other agencies will doubtless want the film, which, we understand, can be rented from the Guidance Center for a nominal fee. For particulars write to the Judge Baker Guidance Center, 38½ Beacon Street, Boston.

### Mental Health and the Movies

During the past two or three years we have seen the movies undergo a moral renovation at the hands of the Legion of Decency and similar bodies. Now they get a clean bill of health from the psychological standpoint from Dr. A. A. Brill, who recently praised them for their contribution to mental health, despite their low estate in the eyes of critics who decry the artistic and educational shortcomings and the superficial character of most of them. But it is just this superficiality that Dr. Brill values as a psychological asset. In the pie-throwing and other "Rabelaisian" antics of the early movie comedians and in the more recent fantastic adventures of Mickey Mouse and his associates of animated-cartoon fame, the cinema, in Dr. Brill's opinion, has furnished new emotional outlets for the average man, woman, and child that cannot be easily duplicated elsewhere in the world of recreation and entertainment.

While the stage has similar advantages from the standpoint of mental catharsis, its possibilities, Dr. Brill holds, are limited and cannot be compared with those of the screen. The actor in a motion picture is only a shadow to his audience, and this, he points out, constitutes a distinct advantage in as much as the spectator can indulge in a casual, yet satisfying, form of escape, which is never as complete when the performers are living beings and a certain degree of emotional transference is inevitable.

Dr. Brill's views on the subject were presented in a lecture on "The Psychiatric Aspects of Motion Pictures" delivered at New York University, on March 4, as part of Professor Frederic M. Thrasher's course on "The Motion Picture, Its Artistic, Educational, and Social Aspects."

"We cannot be emotionally indifferent to people," Dr. Brill explained. "Upon our first contact with a person, we entertain some feeling of like or dislike. Motion pictures, however, are just shadows, and we can dismiss them as such. This is indicated by the fact that people seldom want to see the same picture twice, no matter how good it is. The producers must continually give us new pictures to satisfy the demand." The motion picture is an improved form of entertainment from the psychiatric point of view, he added, and though far from ideal, it is serving a valuable purpose in providing, to some extent, a means to enable us to "live through our primitive instincts vicariously."

### P.W.A. Helps Mental Hospitals

Forging a nation-wide chain of defenses against disease, the Public Works Administration has become America's leading hospital builder. The construction program of this agency has included over two-thirds of all hospitals built during the past three years, according to Administrator Harold L. Ickes' report for 1936. Just as P.W.A. was responsible for three-quarters of all school construction during that period, the report shows that 64 per cent of all hospital construction in the 37 eastern states included in the report was financed with P.W.A. loans or grants.

Analysis of the report shows that approximately $17,000,000 was allotted for construction work at state institutions for the mentally ill and defective and epileptics, of which $14,000,000 was in outright grants and about $3,000,000 in the form of loans. This was equivalent to 40 per cent of the total estimated cost of the new units constructed at these institutions—$40,000,000 for over 300 buildings, providing some 19,000 additional beds in 25 states. It represents an increase of about $10,000,000 in allotments made to mental hospitals since 1933, when the states began to avail themselves of this opportunity for federal aid. Coming at a time when state-hospital budgets were cut to the bone and state funds for construction purposes were scarce, these allotments helped materially to relieve overcrowding, though they represent only a fraction of the amount needed to ease a condition that has become general among the state hospitals of the country in recent years.

Since this report was issued, word has come that large P.W.A. funds have been made available for the relief of congestion in the state institutions in Pennsylvania, with the prospect of immediate construction of the long-projected Western State Psychiatric Hospital at Pittsburgh, which is to serve as a training and research center comparable to university psychopathic hospitals in other states.

### Memorial to Dr. Little

A large group of his former associates, friends, and admirers met at Thiells, New York, on February 12, to honor the memory of the late Dr. Charles S. Little, creator and for more than twenty-five years superintendent of Letchworth Village, state school for the feebleminded. The formal presentation and unveiling of an oil painting of Dr. Little featured the memorial exercises, which were conducted at the institution by F. B. Kirkbride, president of the board of visitors. Paraphrasing Lincoln's Gettysburg Address, Mr. Kirkbride said:

> "We have come here to dedicate an image of the man who conceived and developed what you see here. . . . The world will little note or long remember what we say here, but it can never forget what he did here. It is for us, the living, rather, to be dedicated here to the unfinished work which he has thus far so nobly advanced . . . that we here highly resolve . . . that this institution, under God, shall have a new birth of usefulness and achieve new, continuing, and conspicuous leadership in the threefold purpose to which it is dedicated as Home, School, and Laboratory."

The portrait, which was painted by Henry R. Rittenberg, was presented by Dr. F. C. Shultis of Leominster, Mass., who reviewed Dr. Little's life work and characterized Letchworth as a monument to his achievements and a model to the world. "It gives me great pleasure," Dr. Shultis said, "to present this portrait of Dr. Charles Sherman Little to the state of New York, that it may hang on the walls of this institution and symbolize his untiring effort and zeal which have brought this institution into the foreground of those of its kind; and that its presence may inspire those who follow to emulate his example and carry on as he had begun."

In accepting the portrait on behalf of the state of New York, Dr. Frederick W. Parsons, Commissioner of Mental Hygiene, spoke of Dr. Little as "a strong, vibrant, vital, and stimulating personality—a man who lived, breathed, and fought for this school." And Governor Lehman, in a message transmitted by Dr. Parsons, expressed great satisfaction that in this portrait of Dr. Little installed in the school, "which he served with honor and credit, the state is now possessed of a cherished souvenir of a great personality."

Addresses were also made by Judge Mortimer B. Patterson, of the State Supreme Court, formerly President of the Board of Visitors of Letchworth Village, and by Arthur H. Ruggles, Superintendent of Butler Hospital, Providence, R. I., and President of The National Committee for Mental Hygiene.

Letchworth Village was established while Charles Evans Hughes was governor and now has thirty-six hundred beds.

## 1935 Census Returns

Over 100,000 new cases were admitted to the mental hospitals of the country during 1935, according to preliminary reports of the Federal Census Bureau's latest enumeration of institutionalized mental patients. This brought the total number of patients on the books of these hospitals at the end of the year to 466,045 (416,926 in hospital residence and 49,119 on parole or otherwise absent). The figures are from 172 state hospitals and 2 federal hospitals, 22 veterans' hospitals, 67 county and city hospitals, and 209 private hospitals, making a total of 472 public and private mental hospitals. (Reports were missing from 5 county and city hospitals and 37 private hospitals.) Over 85 per cent of the patients were in state hospitals.

First admissions totaled 101,462, of which 70 per cent went to state hospitals. Two-fifths of the new cases were afflicted with one or another of three types of psychoses: dementia praecox (18.9 per cent); manic depressive (12.1 per cent); and psychosis with cerebral arteriosclerosis (9.7 per cent). As a rule, manic-depressive psychosis and dementia praecox were the most common forms of psychosis among first admissions. Dementia praecox was the most common type of psychosis in the case of public hospitals, while the manic-depressive group was the largest for private hospitals. The second largest group in state hospitals was the manic-depressive; in county and city hospitals, the senile group; in veterans' hospitals, general paresis; and in private hospitals, dementia praecox.

## Advanced Course for Special-Class Teachers

The School of Education of Syracuse University announces advanced courses in teacher training for the mentally handicapped, to be given during its next summer session at Syracuse in coöperation with the New York State Department of Education. The courses are being organized to meet the needs of increasing numbers of experienced teachers and supervisors of special education who want to extend their initial training by further study of the problems in their particular field. In addition to the primary special courses in psychology, mental hygiene, industrial arts, and teaching methods, Syracuse University will offer also advanced and graduate courses in curricular problems, methods, and materials for the slow-learning, reading, speech correction, and vocational guidance, and each student will be afforded an opportunity to work on his or her individual problems. Further information concerning the session can be secured from Dr. Harry Ganders, Dean of the School of Education, Syracuse University.

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